CHAMP Medication & Supplement List

A nurse or other health professional will be at the screening event to review your medications.

Please list all prescription medications, over-the-counter medicines, vitamins or other nutritional supplements, pain relievers, antacids, laxatives, and herbal remedies that you are taking or have recently taken.

Name: _____ Date: _____ Participant ID:_____

Health Professional Review (please initial beside date)

Date/ Initials	Name of Medication (example: Vasotec)	Dose (example: one 5 mg tablet)	When Taken (example: twice a day – 7am & 7pm)

If there are documented interactions between medications, please note with an asterisk (*) and <u>draw lines to connect the medications with interactions</u>. If a medication is associated with an increased risk for falls (e.g., benzodiazepines, anticholinergics, opioids, sedative-hypnotics), please indicate this with a hashtag (#) in the date column. Zolpidem (Ambien) is an example of a medication associated with high falls risk. Please fax all medication lists to the PCP, noting any medication concerns in the accompanying letter.