

DOT Medication Restrictions List

DOT MEDICATION RESTRICTIONS LIST

Tick each item as you gather or confirm it. Add anything specific to your own circumstances in the blank rows.

Name: _____ Date completed: _____ dd / mm / yyyy

Date of birth: _____ dd / mm / yyyy Record / MRN number: _____

Prepared by: _____ Date: _____ dd / mm / yyyy

Tick each item once it is confirmed or packed. Use the blank rows for anything specific to you.

ESSENTIALS

☐ Essentials

DOCUMENTS AND PAPERWORK

☐ Documents and paperwork

USEFUL BUT OPTIONAL

☐ Useful but optional

ANYTHING ELSE

Item: _____ Quantity: _____

Who is bringing it: _____ Confirmed: _____

Item: _____ Quantity: _____

Who is bringing it: _____ Confirmed: _____

Item: _____ Quantity: _____

Who is bringing it: _____ Confirmed: _____

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Item: _____ Quantity: _____

Who is bringing it: _____ Confirmed: _____

Item: _____ Quantity: _____

Who is bringing it: _____ Confirmed: _____

NOTES

Notes