OTC Medication List

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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 items

- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]

DOCUMENTS AND PAPERWORK

Documents and paperwork items

- [ ]
- [ ]
- [ ]
- [ ]
- [ ]

USEFUL BUT OPTIONAL

Useful but optional items

- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]

ANYTHING ELSE

Item: _____ **Quantity:** _____

Who is bringing it: _____ **Confirmed:** _____

Item: _____ **Quantity:** _____

Who is bringing it: _____ **Confirmed:** _____

Item: _____ **Quantity:** _____

Who is bringing it: _____ **Confirmed:** _____

Item: _____ **Quantity:** _____

Who is bringing it: _____ **Confirmed:** _____

Item: _____ Quantity: _____

Who is bringing it: _____ Confirmed: _____

Item: _____ Quantity: _____

Who is bringing it: _____ Confirmed: _____

Item: _____ Quantity: _____

Who is bringing it: _____ Confirmed: _____

Item: _____ Quantity: _____

Who is bringing it: _____ Confirmed: _____

NOTES

Notes