Prostate Medication List

PROSTATE MEDICATION 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: ______________________

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