|  |  |  |  |
| --- | --- | --- | --- |
| Name of child: |  | Children’s home: |  |
| Date of birth: |  | Date of review: |  |
| Placement start date: |  | Child’s Keyworker: |  |
| Date of last CLA medical: |  | Current weight: |  |
| Person responsible for the medication review |  | Role / Designation: |  |

This form is to be completed on arrival at a WSCC Children’s Home and every 3 months thereafter, or sooner if there are changes in the child’s circumstances.

Medication reviews will be required more regularly for young people receiving palliative care including end of life care, requiring frequent or complex monitoring or who have been transferred to the children’s home after hospital discharge.

|  |  |  |
| --- | --- | --- |
| **Known Medication related allergies:** |  | **Any Controlled Drugs:** |
|  |  |  |

|  |
| --- |
| **People attending the review**  |
| **Name**  | **Role/Designation**  | **Agency / organisation**  |
|  | Child  |  |
|  | Parent/carer  |  |
|  | Key worker / residential staff  |  |
|  | LAC Nurse  |  |
|  | Community/ Specialist Nurse  |  |
|  | Pharmacist  |  |
|  | Social Worker  |  |
|  | Other (please specify) |  |

|  |
| --- |
| **Current Prescribed Medication** |
| **Name**  | **Dose**  | **Time**  | **Route**  | **Reason**  |
|  |  |  |  |  |
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| --- |
| **Current Non-Prescribed / Homely Remedies /Over The Counter Medicines** |
| **Name**  | **Dose**  | **Date**  | **Route**  | **Reason**  |
|  |  |  |  |  |
|  |  |  |  |  |
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| --- |
| 1. Does anyone attending the review have any concerns or questions about any medication? (including side effects)
 |
|  |
| 1. How well does the current medication work? How appropriate they are and is their use in line with national guidance?
 |
|  |
| 1. Are any monitoring tests needed?
 |
|  |
| 1. Advice related to administering medicines with agreed foods
 |
|  |
| 1. Does the current medication need to be given covertly?
 |
|  |
| 1. If the young person is over the age of 16 and determined as lacking the capacity to consent to the administration of medication, are they still receiving it in their Best Interests?
 |
|  |

|  |
| --- |
| Action Plan  |
| No.  | Task | Who | Due by | Date completed  |
| 1 |  |  |  |  |
| 2 |  |  |  |  |
| 3 |  |  |  |  |
| 4 |  |  |  |  |
| 5 |  |  |  |  |
| 6 |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name  |  | Signature  |  | Role  |  | Date  |  |
| Name |  | Signature  |  | Role  |  | Date  |  |
| Name  |  | Signature  |  | Role  |  | Date  |  |
| Name  |  | Signature  |  | Role  |  | Date  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date of next review**  |  | **Time** |  | **Location**  |  |