|  |  |  |  |
| --- | --- | --- | --- |
| Name of Person:  |       | DOB: |       |

**This document is protected. Click the grey box in each section to complete the form.**

Reasons why medicines need to be administered covertly and risks if the person does not take their medicine:

|  |
| --- |
|       |

Has an MCA and Best Interest assessment been completed?

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| --- |
|       |

Has a DOLS/ LPS assessment been completed?

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| --- |
|       |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medicine** | **Dose** | **Frequency** | **Reason for Medicine** | **Pharmacist Advice** |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |

|  |  |
| --- | --- |
| Covert method of administering medication: |       |
| Action to be taken if medication is still refused, spat out, etc. |       |
| Date agreement is to be reviewed: |       |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Signed: |       | (Manager) | Date: |       |
| Signed: |       | (GP) | Date: |       |
| Signed: |       | (Relative/Advocate) | Date: |       |
| Please State Relationship:       |
| Signed: |       | (Pharmacist) | Date: |       |