|  |  |  |  |
| --- | --- | --- | --- |
| 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?

|  |
| --- |
|  |

Has a DOLS/ LPS assessment been completed?

|  |
| --- |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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: |  |