Medication

If you are taking any medicines, insulin or tablets, your care providers will write them here. If the dose of these change or you are required to start taking other medicines this can also be written here.

Date recorded	Drug	Dose	Frequency	Comments i.e. discontinued, dose changed
D D M M Y Y				
D D M M Y Y				
D D M M Y Y				
D D M M Y Y				
D D M M Y Y				
D D M M Y Y				
D D M M Y Y				
D D M M Y Y				
D D M M Y Y				

Method of contraception discontinued D D M M Y Y

Consultations

B/P = Blood Pressure.

Date/Time	B/P	Weight (Kg)	HbA1c	Urinalysis	Last mentrual period	Medication
						Signed* / Next contact
						Signed* / Next contact
						Signed* / Next contact
						Signed* / Next contact
						Signed* / Next contact

SAMPLE

Consultations

B/P = Blood Pressure.

Date/Time	B/P	Weight (Kg)	HbA1c	Urinalysis	Last mentrual period	Medication	
						Signed*	Next contact
						Signed*	Next contact
						Signed*	Next contact
						Signed*	Next contact
						Signed*	Next contact
						Signed*	Next contact
						Signed*	Next contact

SAMPLE

Transfer of care

Date of transfer	To	Reason for transfer
D D M M Y Y Y Y		

Name	
Unit No	

* **Signatures must be listed on page 8 for identification**