

# Medication Adherence Checklist

Patient Name:

Date:

Medication List

Medication Name	Dosage	Frequency	Prescribed By
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Adherence Review

- All medications taken as prescribed
- Missed doses (details below)
- Doses changed/stopped

Notes / Reasons for missed or changed doses:

Challenges Identified

Barrier	Yes	No	Comments
Forgot dose(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Side effects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Cost/Access	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

Additional Comments / Recommendations:

Reviewed by:

Review Date: