Medication List (as required by Medicare)

--Please bring a completed list of your medication to your 1st physical therapy visit (the initial evaluation).
--This list should **include all your prescription medications & over-the-counter medications.**
--Please sign & date this list to indicate that you believe it is accurate.

Name	Dosage	Frequency	Route of Administration		
			Pill	Liquid	Other
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

Name: ______________________, Signature: ________________________________, Date: ____________