****

## Appendix 3 – Ongoing Assessment Recording Sheet

**Self-Administration Of Medicines In Hospital: Ongoing Assessment Recording Sheet**

Patient Name:

CHI number:

Date of Birth:

Addressograph

Ward: Hospital:

Based on the questions in the assessment form, please assess whether there are any changes which would require self-administration of medicines to stop or have the level reviewed.

Assessment Frequency (as per SOP):\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Date** | **Current Level** | **Assessment Reviewed (tick)** | **Self-administration continues?** **(document the level)** | **Comments (must be completed if self-administration stops or the level changes)** | **Signature** | **PRINT NAME/****Designation** |
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| **Date** | **Current Level** | **Assessment Reviewed (tick)** | **Self-administration continues?** **(document the level)** | **Comments (must be completed if self-administration stops or the level changes)** | **Signature** | **PRINT NAME/****Designation** |
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