

C-med - improved
C-med - list - improved

**AFRICAN AMERICAN STUDY OF KIDNEY DISEASE AND HYPERTENSION
AASK COHORT STUDY
MEDICATION FORM # 140**

This form should be *entered* at every held visit. All medications should be reviewed and any changes to this form should be made at that time.

--	--	--	--	--	--	--	--

1. Identification Number...

--	--	--	--	--

2. Name Code...

--	--

3. Visit Number...

--	--	--	--	--	--	--	--	--	--

4. Visit Date: mm/dd/yyyy...

5. Medication adjustment record: Look at the last visit's medication flowsheet while the patient is there. List each drug being added or changed by medication name and dose, current dosage of the drug and current frequency. You will be able to enter as many medications as you need. A discontinued medication should be deleted from the form by placing the cursor on the medication name and dose to be deleted and pressing the Shift + F6 keys.

Note: For non-standard dosing, make sure the amount of drug per day, week or month is correct. Also, Insulin and Procrit should be recorded as close as possible to what the patient is taking. "How Many" should equal the number of units per injection, "How Often" should be equal to the frequency of the injections, and "Per What" should equal day, week, month, or as needed (PRN). Do not record volumes for these two categories of medications.

For "Per What?", code 1=per day, 2=per week, 3=per month, and 4=as needed.

For "Medication Schedule", code 1 = morning/wake-up, 2 = afternoon, 3 = evening/bedtime, 4 = morning and evening, 5 = morning, afternoon, and evening, 6 = morning, afternoon, evening, bedtime, 7 = PRN, 8 =other, 9 = unknown. Note, morning is when the participant first wakes up for the day, no matter what time it is.

Be sure to ask about over-the-counter drugs, vitamins, supplements, and antioxidants.

Medication Name and Dose	Form	Strength	ROA	How Many?	How Often?	Per What?	Medication Schedule
				How many	How often	per what	Schedule

200. Date this form completed (mm/dd/yyyy) / /

201. Certification ID of person completing this form

For Clinical Center Use Only:

Certification ID of person entering this form: _____

Date Entered: ____/____/____

