

Medication Action Plan

Any issues or problems that you may have with your medications are listed below. Also listed are concerns that you or your pharmacist brought up during your visit. Your Pharmacist has listed the steps that you can take to fix or avoid these problems. Please share this with your Health Care Provider.

Patient Name _____ Date of Birth _____

Primary Physician _____

Date _____ Medication or Condition of Concern _____

Issue or Problem _____

How you can Fix the Problem _____

Date _____ Medication or Condition of Concern _____

Issue or Problem _____

How you can Fix the Problem _____

Date _____ Medication or Condition of Concern _____

Issue or Problem _____

How you can Fix the Problem _____

Date Prepared _____ Pharmacist Name _____

Phone Number _____

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