Medical Provider List

Full Name: _____ **Address:** _____
Date of Birth: _____ **Phone Number:** _____
Gender: _____

Specialty	Provider Name	Phone Number	Address	Notes/Comments
Cardiologist				
Endocrinologist				
Gastroenterologist				
Neurologist				
Oncologist				
Pulmonologist				
Rheumatologist				
Dermatologist				
Urologist				
Nephrologist				
Allergist/Immunologist				
Psychiatrist				
Other				

This form is confidential and will be used solely for the purpose of providing personal care services and ensuring the client's medication needs are accurately documented and managed.

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Medication Log Instructions

1. **Date:** Enter the date the medication is administered.
2. **Medication Name:** Write the full name of the medication.
3. **Dosage:** Specify the exact dosage the client takes.
4. **Time Administered:** Record the time the medication was administered.
5. **Observed By (Initials):** The initials of the person observing the medication administration.
6. **Notes/Comments:** Any relevant information about the medication administration, such as reactions, missed doses, or special instructions.

Consent and Acknowledgement

I acknowledge that the information provided above is accurate and complete to the best of my knowledge. I authorize Paramount Home Care Services, LLC to use this information to create and manage my medication plan.

Client Signature: _____ Date: _____

Caregiver/Agency Representative Signature: _____ Date: _____

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