

ATTACHMENT J: MEDICATION LIST EVALUATION FORM



**Walworth County Patient Safety Council
Medication List Evaluation Form / 2006**

Medication List A B C

Community Group _____

Date ___ - ___ - ___ Age _____ Sex Male Female

Number of prescription medications you take each day _____

Number of medications you take each day that you buy without a prescription, like vitamins and herbals _____

Do you manage your medications yourself? Yes No



Please answer the following questions about these medication lists.

1. Evaluate the size of the medication list.

1 Poor 2 Fair 3 Neutral 4 Good 5 Excellent

Comments: _____

2. Evaluate the usefulness of the information on the medication list to keep track of your medications.

1 Poor 2 Fair 3 Neutral 4 Good 5 Excellent

3. Would you use this medication list?

Yes No Undecided

4. How would you improve this medication list?

5. How would you rate this medication list on a scale of 1 to 5?

1 Poor 2 Fair 3 Neutral 4 Good 5 Excellent

