Medication Administration Record (MAR) (Complete accurately, legibly and in Ink)

Name:	Date of Birth:	
Address:	Known allergies:	
Doctor's name:	Doctor's telephone:	
Start date for sheet (month and year):	Sheet number of	(total number)

	Week commencin					ing	date Week commencing date									Week commencing date							Week commencing date						W/c date			
Medication details	Time	М	Т	W	Th	F	Sa	Su	М	Т	W	Th	F	Sa	Su	М	Т	W	Th	F	Sa	Su	М	Т	W	Th	F	Sa	Su	М	Т	W
Medicine name, dose and route:																																
Quantity, frequency, any special inf'n																																
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Key: R= Refused S=Sleeping D=Destroyed N=Nausea/Vomiting O=Other Note: If you enter a code (as above), please ensure you make a record of the reason for this in the care notes/diary.

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		We	ek c	omn	nenc	ing	date		We	eek commencing date					Week commencing date						Week commencing date						W/c date					
Medication details	Time	М	Т	W	Th	F	Sa	Su	М	Т	W	Th	F	Sa	Su	М	Т	W	Th	F	Sa	Su	М	Т	W	Th	F	Sa	Su	М	Т	W
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Other medicines "Pro Re Nata" - "as required":

Medicine name; dose; frequency	Date	Time	Initials	Date	Time	Initials	Date	Time	Initials

Key: R= Refused S=Sleeping **D=Destroyed** N=Nausea/Vomiting **O=Other** Note: If you enter a code (as above), please ensure you make a record of the reason for this in the care notes/diary.