# <<Date>>

<<Member\_First\_Name>> <<Member\_Last\_Name>>

<<Member\_Address\_Line1>>

<<Member\_Address\_Line2>>

<<Member\_City>>, <<Member\_State>> <<Member\_Zip>>

Dear <<Member\_First\_Name>> <<Member\_Last\_Name>>,

Thank you for talking with me on <<Date>> about your medications and health needs. The Medication Management program helps make sure that your medications are working as planned and are getting the best outcomes.

With this letter is your medication list. This list helps track your medications. It will also help you use them the right way. Ask your doctor and other healthcare providers to update them at every visit. If you go to the hospital, take this list with you so you can get the right treatment without delays.

If you have questions about this, call <<Phone number>> Monday through Friday, 9:00 am to 5:00 pm.

Sincerely,

<<Clinican Name>>

**Medication Action Plan For <<Member First Name, Last Name>>**

**DOB:<<Member DOB>>**

This Medication Action plan was prepared for you after we talked. This will help summarize our discussion.

* Read “What we talked about.”
* Take the steps listed in “What I need to do” section
* Fill in “What I did and when I did it.”
* Fill in “My follow-up plan.”
* Have this action plan ready with you when you visit with your providers next.
* Ask your doctor or other healthcare providers about any questions or concerns you may have.

**What we talked about:**

* + (Example) High Cholesterol

**Date Prepared:**

**What I need to do:**

**What I did and when I did it:**

* Monitor diet; eat fewer high cholesterol

foods (see dietary handout for healthier options).

* Get your cholesterol checked.

**What we talked about:**

**What I need to do:**

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**What I did and when I did it:**

**My follow-up plan (add notes about next steps):**

**Questions I want to ask (include topics about medication or therapy):**

**Medication List For <<Member First Name, Last Name>>**

**DOB: <<Member DOB>>**

Your medication list was made after we talked.

* Use the blank rows to add new medications you may start in the future.
* Cross out medications you no longer use and add the reason why you stopped.
* Ask your doctor or healthcare providers to update the list every visit.
* If you go to the hospital, take this list.

**Date Prepared:**

|  |
| --- |
| Allergies or side effects: |

|  |  |
| --- | --- |
| Medication: | |
| How I use it: | |
| Why I am on this medication: | |
| Doctor’s Name: | |
| Date I started on the medication: | Date I stopped using it: |
| Why I stopped using it: | |

|  |  |
| --- | --- |
| Medication: | |
| How I use it: | |
| Why I am on this medication: | |
| Doctor’s Name: | |
| Date I started on the medication: | Date I stopped using it: |
| Why I stopped using it: | |

|  |  |
| --- | --- |
| Medication: | |
| How I use it: | |
| Why I am on this medication: | |
| Doctor’s Name: | |
| Date I started on the medication: | Date I stopped using it: |
| Why I stopped using it: | |

|  |  |
| --- | --- |
| Medication: | |
| How I use it: | |
| Why I am on this medication: | |
| Doctor’s Name: | |
| Date I started on the medication: | Date I stopped using it: |
| Why I stopped using it: | |