

Medication Administration Record (MAR)

| Date: | | Facility: Nananom Assisted Living | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Medication | Hour | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
| | Start | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| | Stop | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Start | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| | Stop | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Start | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| | Stop | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Start | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| | Stop | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Start | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| | Stop | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Diagnosis: | | Diet: (Special instructions, e.g., texture, bite size, position, etc.) | | | | | | | | | | Comments: | | | | | | | | | | | | | | | | | | | | |
| Allergies: | | PCP name: | | | | | Phone number: | | | | | A. Put initials in appropriate box when medication is given. B. Circle initials when not given. C. State reason for refusal/omission on the back of this form. D. PRN medications: Reason given, and results must be noted on the back of this form. E. Legend: H = Hospice home visit, Dc'd = Discontinued, R= Refused | | | | | | | | | | | | | | | | | | | | |
| | | Hospice agency: | | | | | Phone number: | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Resident's name: | | | | | | | | | | Room # | | | | | Date of birth: | | | | | Sex: | | | | | | | | | | | | |
| Caregiver: | | Initial: | | Shift: | | Caregiver: | | | | | Initial: | | Shift: | | | | | | | | | | | | | | | | | | | |
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Caregiver initials must be done every time a medication is administered.