Medication List for PQRS Reporting

Date: _____

Patient: _____

**In keeping in compliance with Medicare requirements, please provide a list of ALL prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional supplements), as well as the dosage, frequency, and route of administration. Attach additional pages if necessary.*

Medication: **Dosage/Frequency:** **Route of Administration:**

_____

_____

_____

_____

_____

_____

_____

Re-Assessments

Date: _____Is the above list complete: _____ Yes _____ No (see changes below)

_____

_____

Date: _____Is the above list complete: _____ Yes _____ No (see changes below)

_____

_____