Queensland Government

Young Person's Medication Change Plan
(twice a day medication)

Facility: Brisbane Child Neurology

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

Responsible Consultant: Dr Ubaid Shah

Date document created: 19/12/2017 **Current weight:**

Medication changes advised

	Medication 1: (name, preparation e.g. tablet, strength)		**Medication 2:** (name, preparation e.g. tablet, strength)	
Week / Day Number (circle)	**AM dose (mg or mLs)**	**PM dose (mg or mLs)**	**AM dose (mg or mLs)**	**PM dose (mg or mLs)**

Who to contact if concerns arise during medication changes (e.g. side effects)

Name:	Position:	Contact (phone/page):

Completed by:

Doctor's name:	Position:	Contact (phone/page):
Dr Ubaid Shah	Paed Neurologist and Epileptologist	3163 3636
Institution: Brisbane Child Neurology	**Signature:**	**Date:**

DO NOT WRITE IN THIS BINDING MARGIN

YOUNG PERSON'S MEDICATION CHANGE PLAN (TWICE A DAY MEDICATION)

v1.00 - 02/2014

SW535