**SELF-ADMINISTRATION ASSESSMENT FORM**

Resident Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Room Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interdisciplinary team members:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Medications: (list only those that the resident wants to self administer)

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Assessment:

1. Cognitive ability:

Adequate Limited Not Adequate (choose one)

If limited or not adequate, indicate reasons:

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2. List any physical limitations to safe administration:

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3. Special problems with complexity, difficulty or other reasons:

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4. Special medication needs (i.e. NTG):

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**SELF-ADMINISTRATION ASSESSMENT FORM**

(Continued)

IDT Determination:

Indicate the specific level approved or describe any restrictions on one or more medications. If recommending not to permit self-administration, explain why:

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If approved, attach resident instruction documentation and note physician order in the medical record.

Nurse assessing resident:

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