CLEVELAND Hearing & Speech CENTER℠

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4257 Mayfield Road · South Euclid, OH 44121 · 216-382-4520 · 216-325-7609 Fax
7000 Town Centre Drive #200 · Broadview Heights, OH 44147 · 440-838-1477 · 216-325-7620 Fax

As part of our efforts to ensure comprehensive, high quality care, we strive to maintain accurate, comprehensive records. Please provide all data requested on this form so that we have relevant, current information in case of an emergency. The office manager will periodically request that you complete this form to ensure our records are up to date. **If you take this form with you and wish to mail it back, please mail it to the address circled on the left.**

MEDICATION FORM

Client Name: _____ DOB: _____

Client Phone:_____ Cell Phone: _____

Caregiver Name: _____ Caregiver Phone (if different): _____

Emergency Contact Name:_____ Phone:_____

MEDICATIONS – Please copy information from the label on the medication.

Medication Name	Dosage	Prescribing Physician	Prescribing Physician's Phone	Reason for Medication

I attest that the medications listed on this form are accurate:

_____ _____

Client/Caregiver/Guardian Signature *Date*

❑ **"I acknowledge receiving a copy of the Notice of Privacy Practices."** _____ _____

Client/Caregiver/Guardian Signature *Date*