SLRC
St. Lawrence Rehabilitation Center

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Medication List

Patient Name _____ Account # _____

Please complete this medication list with all prescription drugs as written on your drug bottle(s):

Medication	Dose	Times	How long have you been taking?

What over-the-counter drugs or herbal remedies do you take? None ☐

Drug / Herbal Product	Amount	Frequency

Medication list reviewed with patient: _____

Therapist Signature