Supplement 3 Croydon Clinical Commissioning Group NHS

Appendix 3 Administration of Covert Medication Review Form

(Complete for each medication separately and refer to checklist App 4)

Name of service user **Date of birth**

Date of initial best interest meeting **Date of this review**

Name, form, strength and dose of medicine:

Have there been any changes to the condition of the service user? If so explain what changes	
Is medication still necessary? If so, explain why	
Is covert administration still necessary? If so explain why.	
Who was consulted as part of this review?	
Is documentation still in place and valid?	
Confirm that the checklist (App 4) has been referred to and considered	Yes/No *Delete as appropriate*
Date of next review	

Signed (Name of prescriber)

Date

To be stored in service users notes

Appendix 3- Review 4 Dec 2015 – Approved by CPC 8th January 2016
Supported by the Croydon CCG MCA development programme