MEDICATION MANAGEMENT INSTRUMENT FOR DEFICIENCIES IN THE ELDERLY (MedMaIDE™)

What a Person <u>Knows</u> About Their Medications **Have the individual…**	**YES**	**NO**
**1. Name all the medications taken each day including prescription and over-the-counter medications (including milk of magnesia, nutritional supplements, herbs, vitamins, Tylenol, etc.).		
**2. State the time of day each prescription medication should be taken.		
**3. Tell how each medication should be taken (by mouth, with water, on skin, etc.).		
**4. State why he/she is taking each medication.		
**5. State the amount of each medication that should be taken at each time during the day.		
6. Identify if there are problems after taking the medication (i.e., like dizziness, upset stomach, constipation, loose stool, frequent urination, etc.).		
7. Do you get medication help from anyone? If YES, by whom? Type of help?		
8. What other medications do you have on hand or available? (i.e., eye drops, creams, lotions, or nasal sprays that are outdated, unused or discontinued).		
If a Person Knows <u>How To Take</u> Their Medications **Ask the individual to…**	**YES**	**NO**
**1. Demonstrate filling a glass with water.		
**2. Remove top from medication container (vial, bubble pack, pill box, etc.).		
**3. Demonstrate counting out required number of pills into hand or cup.		
**4. Demonstrate administering medication (e.g., put hand with medication in it to open mouth; put hand to eye for eye drops; hand to mouth for inhaler; draw up insulin, or place a topical patch).		
**5. Sip enough water to swallow medication.		
Record how the medications are currently being stored.		

Reference: Orwig D, Brandt N, Gruber-Baldini A. Medication management assessment for older adults in the community. *The Gerontologist.* 2006; ***46***(5): 661-668. Please contact author prior to using this form at (410) 706-8951 or via email dorwig@som.umaryland.edu or nbrandt@rx.umaryland.edu

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If a Person Knows <u>How to Get</u> Their Medications **Have the individual…**	**YES**	**NO**
**1. Identify if a refill exists on a prescription.		
**2. Identify whom to contact to get a prescription refilled.		
**3. Explain resources needed to obtain the medication. (can arrange transportation to pharmacy, pharmacy delivers, daughter picks it up, etc.).		
4. After getting a new refill, do you look at the medication before you take it to make sure it is the same as the one you finished?		
5. Do you have a prescription card? YES NO Do you use your prescription card? YES NO If YES : specify type:_____		
6. Are there medications that you need that you cannot obtain? YES NO If YES, ask resident to explain.		

** If **NO**, it is counted as a 1 in the Deficiency Score

TOTAL DEFICIENCY SCORE: _____
(sum of three deficiency scores: maximum total score=13)

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MEDICATION NAME	DOSAGE	TIME (S) of Day Taken	EXPIRATION DATE	PHYSICIANS NAME/PHONE	PHARMACY NAME/PHONE

NOTES:

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