Wooster Community Hospital Community Care Network
Medication List

Patient's Name: ______________________________ DOB:___________________________

Medication Name and Strength (i.e. Citalopram 20 mg, Advair 250/50 mg)	**Form** (i.e. XR, SR, may leave blank if not specific)	**Dose** (i.e. 3 tablets, 50 mg, 2 puffs, 1 spray)	**Directions with times**, if known (i.e. daily, twice daily with meals, bedtime)