My Medication Information

Please use this worksheet as a helpful form when setting up your medications online or by phone, mail, or fax.

Name ____________________________________________
GreatCall phone # ___________________________________

Medication 1:
Prescription Name: __________________________________
Days I take this (please circle): Sun Mon Tue Wed Thu Fri Sat Every Day
Times of Day I take this:
Dosage 1: __________ am pm (please circle)
Dosage 2: __________ am pm (please circle)
Dosage 3: __________ am pm (please circle)
Special Instructions (i.e. take with food): ____________________________

Medication 2:
Prescription Name: __________________________________
Days I take this (please circle): Sun Mon Tue Wed Thu Fri Sat Every Day
Times of Day I take this:
Dosage 1: __________ am pm (please circle)
Dosage 2: __________ am pm (please circle)
Dosage 3: __________ am pm (please circle)
Special Instructions (i.e. take with food): ____________________________

Medication 3:
Prescription Name: __________________________________
Days I take this (please circle): Sun Mon Tue Wed Thu Fri Sat Every Day
Times of Day I take this:
Dosage 1: __________ am pm (please circle)
Dosage 2: __________ am pm (please circle)
Dosage 3: __________ am pm (please circle)
Special Instructions (i.e. take with food): ____________________________

Medication 4:
Prescription Name: __________________________________
Days I take this (please circle): Sun Mon Tue Wed Thu Fri Sat Every Day
Times of Day I take this:
Dosage 1: __________ am pm (please circle)
Dosage 2: __________ am pm (please circle)
Dosage 3: __________ am pm (please circle)
Special Instructions (i.e. take with food): ____________________________

Medication 5:
Prescription Name: __________________________________
Days I take this (please circle): Sun Mon Tue Wed Thu Fri Sat Every Day
Times of Day I take this:
Dosage 1: __________ am pm (please circle)
Dosage 2: __________ am pm (please circle)
Dosage 3: __________ am pm (please circle)
Special Instructions (i.e. take with food): ____________________________

Medication 6:
Prescription Name: __________________________________
Days I take this (please circle): Sun Mon Tue Wed Thu Fri Sat Every Day
Times of Day I take this:
Dosage 1: __________ am pm (please circle)
Dosage 2: __________ am pm (please circle)
Dosage 3: __________ am pm (please circle)
Special Instructions (i.e. take with food): ____________________________

Medication 7:
Prescription Name: __________________________________
Days I take this (please circle): Sun Mon Tue Wed Thu Fri Sat Every Day
Times of Day I take this:
Dosage 1: __________ am pm (please circle)
Dosage 2: __________ am pm (please circle)
Dosage 3: __________ am pm (please circle)
Special Instructions (i.e. take with food): ____________________________

Medication 8:
Prescription Name: __________________________________
Days I take this (please circle): Sun Mon Tue Wed Thu Fri Sat Every Day
Times of Day I take this:
Dosage 1: __________ am pm (please circle)
Dosage 2: __________ am pm (please circle)
Dosage 3: __________ am pm (please circle)
Special Instructions (i.e. take with food): ____________________________

Fax: 1-760-438-9790   Mail: Attn. MyLife Assistance Team Greatcall Inc. P.O. Box 4428 Carlsbad, CA 90218-9839