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

What a Person Knows About Their Medications	**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 for each prescription medication to be taken		
**3. Can you tell me how the medications should be taken (by mouth, with water, on skin, etc.)		
**4. State why he/she is taking each medication		
**5. Tell me the amount of each medication to 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. Does the resident 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 (i.e., eye drops, creams, lotions, or nasal sprays that are outdated, unused or discontinued)		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 How To Take Their Medications	**YES**	**NO**
**1. Can fill a glass with water		
**2. Can remove top from medication container (vial, bubble pack, pill box, etc.)		
**3. Can count out required number of pills into hand or cup		
**4. Can 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.		
If a Person Knows How to Get Their Medications	**YES**	**NO**
**1. Identify if a refill exists on a prescription		
**2. Identify who to contact to get a prescription refilled		
**3. Do you have resources to obtain the medication? (Can arrange transportation to pharmacy, pharmacy delivers, daughter picks it up, etc.)		

Reference: Orwig D. Brandt N. Gruber-Baldini AL. (2006) Medication Management Assessment for Older Adults in the Community. Gerontologist. 2006;46:661-668. Please contact author(s) prior to using this form at respective numbers (410) 706-8951 or (410) 706-1491 or via email dorwig@epi.umaryland.edu or nbrandt@rx.umayland.edu.

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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)

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

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