

# Self – Administration Assessment

(p1 of2)


Name of Individual: \_\_\_\_\_  
Signature and Title of Person Observing Assessment (2 required). Form should be completed by the provider that best knows the individual and a County Board Employee or representative.

\_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_


\_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Persons conducting assessment will need to have ALL necessary information regarding the individual's current medications including medicine name(s), dose(s), route(s), time(s), reason for medication(s), and basic side effects. See reverse side for additional documentation.


1. I can recognize my medication by color, size, shape and/or by reading the label. I will not take my medicine if it looks different.

YES  Go to 2.      NO  Go to 


2. I can tell you what my medicine is for (pain, nerves, breathing).

YES  Go to 3.      NO  Go to 


3. I know and recognize how much medicine I'm to take (1/2 pill, the cup filled to this line). I will not take my medicine if it is the wrong amount.

YES  Go to 4.      NO  Go to 


4. I will recognize and know who to tell if I don't feel good (pain, nausea, dizzy). It may be a side effect.

YES  Go to 5.      NO  Go to 


5. I know who to tell when I have 3-4 days of medicine left so I never run out.

YES  Go to 6.      NO  Go to 



6. I know who to call if my medicine is wrong and will tell him/her right away.


YES  Go to 7.      NO  Go to 


7. I take my medicine at the right time every day by using the clock or my routine (after the news, before lunch, etc).


YES  Go to 8.      NO  Go to 


8. I can get medication to and from storage, out of the container and to my mouth without spills.

YES   and NOTE      NO  Go to  & NOTE

  
**Unable to Self Administer With or Without Assistance**  
*Will Require Medication Administration Certified Staff to Administer Medication*  
Continue to next assessment question.  
Complete this form in its entirety.

  
**Self Administer With Assistance**  
*Service Plan to Include Time Reminder*  
**Continue To 8**

  
**Self Administer With Assistance**  
*Service Plan to Include Assist with Removal from Storage Removal from Container And/or To my mouth*

  
**Self - Administer Without Assistance**  
(answered YES to all 8 questions)

**NOTE:**  
Reasons this form shall be completed again in its entirety include but are not limited to:  
◀ Client moves  
◀ Medication Packaging changes  
◀ Client has change in health status  
◀ Client exhibits changes in behaviors

Once the assessment is completed, the service plan for the individual should specify how medication administration will be done. Any of the following statements could be used in their service plan depending on what is correct for each specific person.

- I can self-administer medication(s) without assistance.
- I can self-administer medication(s) with assistance (select one of the following related to the assistance).
  - The individual receives assistance with self-administration of medication(s) through reminders of when to take the medication(s). Specify reminders needed in the client's ISP.
  - The individual receives assistance with self-administration of medication(s) through physically handing the medication container to client. Provide specific instructions in the client's ISP.
  - The individual is physically impaired and the provider may open the medication container for the individual to assist with self-administration of medication. Place specific instructions in the ISP.
  - The individual is physically impaired and the provider physically assists them with opening the medication container and getting the medication to their mouth to prevent spilling, therefore, assisting with self-administration of medication. Place specific instructions on the client's ISP

**Other:**

- I need certified staff to administer my medication. Use this if answer to any question leads you to the top box on the right side of this form. If any question, #1-6 is answered "no" use this answer.
- I require certified staff to administer my medications while I am learning to self-medicate. IP Team should consider Skill Development programs as appropriate. Use this answer if the client cannot consistently self-medicate. A specific plan should be written with goals and time frames. See 5123:2-6-02 (C).
- I can self-administer specific medication or task (ie. Inhaler, nebulizer, sublingual, etc.)
  - Describe medication and/or task \_\_\_\_\_
  - Ability Level with task \_\_\_\_\_
  - Designate if independence or staff administration of a task/ medication is applicable to a specific location or time of day (ie. Work setting) \_\_\_\_\_
- I have demonstrated unsafe behaviors and am therefore unable to self-administer medication with or without assistance. Identify behavior / justification.

If the client has a history of unreliability or noncompliance the person doing the assessment may indicate that the client requires med administration for his / her own safety.

**RESULT:**

- Self Administration with assistance
- Self Administration

**Medication Administration/ Delegated Nursing (DN)**

- I live in a 5 bed or less setting and will receive my medication from staff that have a level one certification for medication
- (or)**
- I will receive DN services per the state DN rules

**Medication(s) assessed at this time:** (Attach another page if more space needed – or copy of MAR)

Medication Name	Dose	Route
_____	_____	_____
_____	_____	_____

**Reviewed by:**

SERVICE SUPPORT ADMINISTRATOR / COORDINATOR (signature & date): \_\_\_\_\_

NURSE (signature & date): \_\_\_\_\_