DSHS
WASHINGTON STATE
Department of Social and Health Services

Assisted Living Facility
Medication Pass Worksheet

ASSISTED LIVING FACILITY NAME		LICENSE NUMBER
ENTRANCE DATE	LICENSOR NAME	

Inspection Type: ☐ Full ☐ Follow up ☐ Complaint: Number _____

This form is required **only** if a problem with medications has been identified.

RESIDENT NAME AND ID NUMBER	DRUG PRESCRIPTION NAME, DOSE AND FORM	OBSERVATION OF ADMINISTRATION	DRUG ORDER WRITTEN AS (WHEN DIFFERENT FROM OBSERVATION
ID NUMBER:			
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Notes	Attachment Q