Attachment Q

Washington State Department of Social & Health Services
Transforming lives

Assisted Living Facility Medication Pass Worksheet

ASSISTED LIVING FACILITY NAME	LICENSE NUMBER
INSPECTION DATE	LICENSOR NAME

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

This form is completed only after 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
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Additional Notes	Attachment Q