DHS
Oregon Department of Human Services
Public Health Division
HIV/STD/TB Program
HIV Care and Treatment Program

Medication Profile

"Confidential — this form must always be saved on a secure network accessible only by Ryan White funded staff."

Required form

Client name: _____ Client #: _____ CM initial: _____ Date: _____

Current medication profile

Date prescribed	Medication	Dose	Frequency	Route	Date d/c'd

Nurse signature and credentials: _____ Date: _____