**

**Empower Supported Housing**

**Self-Administration of Medicines (SAM) Assessment Form**

**Instructions**

This form is to be completed by the referring agency for potential residents who are currently prescribed medication for any health-related conditions (mental or physical). If the resident is not on any medication, this form does not need to be completed.

Please inform the resident that **Empower Supported Housing does not administer medication**. It is the resident’s responsibility to manage their own medicines. This will be further discussed with the resident during the interview stage.

**Resident Information**

|  |  |  |
| --- | --- | --- |
| **Resident Name** | **Date of Birth** | **Assessment Date** |
|  |  |  |

**Self-Administration Responsibility**

Empower Supported Housing enables residents to manage their own medication safely. You are required to:

* Keep your medication in a secure location.
* Take your medication as prescribed by your healthcare provider.
* Inform staff of any changes to your medication or dosage.
* Contact your GP or visit A&E if you experience any side effects or have concerns about your medication.

**Medication Information**

Please list the resident’s current medications, including dosage and reason for taking them:

|  |  |  |
| --- | --- | --- |
| **Medication Name** | **Dosage** | **Reason for Taking** |
|  |  |  |
|  |  |  |
|  |  |  |

**Assessment Questions**

Please complete the following questions based on the resident’s ability to self-administer medication:

|  |  |  |  |
| --- | --- | --- | --- |
| **Question** | **Yes** | **No** | **Comments/Details** |
| Has the medication been prescribed by a GP? |  |  |  |
| Is the resident currently managing their own medication? |  |  |  |
| Is the resident physically and mentally capable of self-administration (e.g., opening containers)? |  |  |  |
| Can the resident read and understand medication labels? |  |  |  |
| Does the resident know what each medicine is for? |  |  |  |
| Does the resident know the correct dosage for each medication? |  |  |  |
| Does the resident know how to take their medication (e.g., with food, at specific times)? |  |  |  |
| Does the resident understand what to do if they run out of medication? |  |  |  |
| Does the resident know how to seek help if there is a problem with the medication? |  |  |  |

**Medication Safety Guidelines**

* **Never exceed the prescribed dosage** or change your medication without consulting your doctor.
* **Do not share your medication** with others.
* Inform staff if you change medications or adjust your dosage.
* Keep your medication out of reach of children and store it safely.

**Resident Consent to Self-Administer Medication**

By signing this form, you acknowledge that:

* You have been informed about self-administration of medicines at Empower SH
* You understand that the responsibility for taking and managing your medication lies with you.
* You agree to store your medicines safely and follow the prescribed dosage.
* You will inform staff if any changes to your medication occur.
* You understand the risks and responsibilities involved in managing your own medication.

|  |  |  |
| --- | --- | --- |
| **Resident Name** | **Resident Signature** | **Date** |
|  |  |  |

**Staff Confirmation**

I confirm that the resident has been fully informed about self-administration of medication and has agreed to take responsibility for managing their medicines.

|  |  |  |
| --- | --- | --- |
| **Staff Name** | **Staff Signature** | **Date** |
|  |  |  |