



# CLIENT SELF-ADMINISTRATION ASSESSMENT FORM

<b>Location:</b> _____	<b>Date of Determination:</b> _____
<b>Consumer's Name:</b> _____	<b>Case#:</b> _____

	YES	NO
1. The consumer has effectively verbalized understanding of the purpose for the medication(s)		
2. The consumer has effectively verbalized common possible side effects, including: i. What to do if dose is missed ii. What to do if extra does(s) taken iii. What to do if adverse reactions occurs		
3. The consumer can recognize the medication(s)		
4. The consumer can perform return demonstration of self administration of medication(s) to include appropriate documentation		

The MAS RN/LPN shall make one of the following determinations:	YES	NO
a. CAN self medicate independently		
b. CANNOT self medicate independently		
c. Can self medicate with LIMITED assistance		
d. Can self medicate, but REFUSES to do so		
e. Assistance with medications by MAC Worker authorized by MAS Nurse		

**SIGNATURE OF MAS RN/LPN MAKING THE DETERMINATION:**

**MAS RN/LPN NOTES:**

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