

WISE and WELL with Donna Bartlett

DEPRESCRIBING FORM

Name: _____ Date: _____

Medication: _____

Why is this medication being deprescribed/optimized? _____

Deprescribed: _____ Changed to: _____

_____ Reduced: _____

_____ Stopped: Date: _____

Taper: _____ Yes _____ No

If yes, taper instructions: _____

Monitor: _____ Lab work: _____ Date: _____

_____ Check and keep a log

(Examples: blood pressure, heart rate, blood glucose, weight)

Date: _____ Time: _____ Result: _____

How do I feel? _____ No different

_____ Not so good because _____

_____ Better, I notice that _____

*Note: Be certain to work with your health care provider regarding deprescribing.

Use the back of this sheet to keep a list of self-monitoring and notes.