SELF ADMINISTRATION OF MEDICATION (SAM) ASSESSMENT TOOL

Name: Residence:

QMRP/Case Manager: Nurse:

Evaluate the individual's ability to participate in a self-medication program by placing a check in the appropriate box and providing comments

TASK	Yes	No	SUPPORT NEEDED	COMMENTS
Responds when name is called	☐	☐	☐ Requires physical prompt or gesture ☐ Other	
Time concept recognition ☐ am ☐ pm ☐ breakfast ☐ lunch ☐dinner/supper ☐ bedtime ☐day of week	☐	☐	☐ Requires pictures to recognize correct time of day to receive medication ☐ Other	
Understands basic number concepts and is able to count from 1 to 3	☐	☐	☐ Requires counter or assistance from staff ☐ Other	
Identifies different colors	☐	☐	☐ Requires picture to reference pill shape ☐ Other	
Discerns different shapes	☐	☐	☐ Requires picture to reference pill shapes ☐ Other	
Identifies his/her name on medication bottle/drawer	☐	☐	☐ Requires special sticker/ symbol to recognized personalized medication container ☐ Other	
Names medication s/he receives	☐	☐	☐ Needs to write medication name to verify	
Knows correct dosage of medication	☐	☐	☐ Requires prompts	
Opens and closes medication containers	☐	☐	☐ Needs assistance	
Pours correct dosage of medication	☐	☐	☐ Needs assistance	
Obtains an adequate amount of medication	☐	☐	☐ Needs assistance	
Puts medication in mouth	☐	☐	☐ Needs assistance	
Obtains adequate amount of fluid to take medication	☐	☐	☐ Needs assistance	
Writes name initials on MAR	☐	☐	☐ Needs assistance	

Based on this evaluation and observation, place a check on the appropriate box for recommendation:

☐	Individual is not able to administer medication to him/her at this time and is not recommended for the "Self Administration of Medication" training program at this time.
☐	Individual is capable of self-administering medication w/ assistance and under close supervision. and/or hands on assistance. The individual will participate in the med. administration and will start an individual training program.
☐	The individual has the potential to self administer medication independently and safely. The individual is recommended by the team to start an individual training program.

Signature of RN completing assessment: _____ Date: _____

☐ Not recommended for self-medication program ☐ Recommended for self medication program

Signature of Physician: _____ Date: _____