MEDICATION SCHEDULE TEMPLATE DATE: _____

AM	_____ _____ _____ _____
NOON	_____ _____ _____ _____
DINNER	_____ _____ _____ _____
NIGHT	_____ _____ _____ _____

Name of medication	***Generic name***	***Dosage***	***Frequency***

PRIMARY CARE DOCTOR: *Dr.* _____ ***PH***: _____

MOVEMENT DISORDER DOCTOR: *Dr.* _____ ***PH***: _____