CHI no .....

First name ..... DOB ...../...../.....

Last name ..... Sex: ☐M ☐F

Address .....

.....

or attach addressograph label here

Current location of patient:
(specify hospital and ward/care home/patient's home/other)

.....

NHS Lanarkshire

Covert Medication Pathway Review

A copy of this record should be transferred when the individual moves between care settings

Does the individual still lack capacity?	☐ Yes
Is covert administration of all medicines on original covert medication pathway still necessary?	☐ Yes ☐ No **If so, explain why:**
Are any new medicines required to be given covertly?	☐ Yes ☐ No **If yes, explain why and give their names:**
Who was consulted as part of the review? e.g. Responsible Medical Officer, Family, GP, Named Person, Advocate, Welfare Guardian, Welfare Attorney.	
Is legal documentation still in place and valid? The documentation must be reviewed.	☐ Yes
Identify date of next planned review:	**Date of next review:** .....

Completed by: (PRINT NAME)	**Designation:**
Signature:	**Date:** ...../...../..... **Time:** ..... : .....

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