CONCOMITANT MEDICATIONS

Has the patient taken any concomitant medications up until day X? No Yes If yes: please describe below																													
Medication Generic/ Trade Name	Indication	Total daily dose & Units	Highest daily dose & Units	Code			Route			Date	DD-	D-MMM-YYYY)					Date stopped (DD-MMM-YYYY)												
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Code 1 = Sedatives 2 = Analgesic: 3 = Neuromus 4 = Anti-Epilep	s cular Blockers	6 = Antibiotics						Route iv = intravenous ih = inhaled im = intramuscular pr = rectal							pv = vaginal po = oral sc = subcutaneous to = topical														