**Appendix 5 – Review Form for Covert Administration**

Please provide a copy of this form to the carer(s) supporting the patient and scan into patient notes in surgery.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Patient** |  | **Date of Birth** |  | |
| **Location** |  | **Date of Review** | |  |

|  |  |
| --- | --- |
| **Is the medication still necessary?**  **If so, explain why** |  |
| **Is covert administration still necessary?**  **If so, explain why** |  |
| **Who was consulted as part of the review?** |  |
| **Is legal documentation still in place and valid?**  **(MCA assessment and evidence of Best Interest discussion)** |  |
| **Date of next review:** |  |

**Prescriber/Pharmacist name: Signature: Date:**

**Senior Carer/Nurse name: Signature: Date:**