PUBLIC HEALTH DIVISION
CENTER FOR HEALTH PROTECTION
Oregon Psilocybin Services
http://oregon.gov/psilocybin

CLIENT MEDICATION AND MEDICAL/ASSISTIVE DEVICE FORM

A client must review and complete a Client Medication and Medical/Assistive Device Form with a facilitator prior to participating in an administration session. Please use this form to document any prescription medications, non-prescription medication or nutritional supplements, medical device(s), mobility, or assistive communication device(s) the client will need during their administration session, but for which the client **does or does not require assistance** to administer or use.

This form must be filled out if a client answers yes to the following questions in the Client Information form: (3)(d), (3)(e), (3)(f), (3)(g), (3)(l), or (3)(m). If a client needs assistance from a client support person for any of the issues indicated below, the Client Interpreter or Client Support Person Plan form must be reviewed and completed.

Client Name: _____

Date: _____

☐ Client will take prescription medications, non-prescription medication or nutritional supplements during their administration session and **requires assistance** to administer the medications, non-prescription medication or nutritional supplements. Client will complete a Client Support Person Plan.

☐ Client will take prescription medications, non-prescription medication or nutritional supplements during their administration session and **does not require assistance** to administer the medications, non-prescription medication or nutritional supplements to themselves.

Please list the prescription medications, non-prescription medication or nutritional supplements:

☐ Client will use a medical device during their administration session and **requires assistance** to use the device(s). Client will complete a Client Support Person Plan.

☐ Client will use a medical device during their administration session and **does not require assistance** to use the device(s) themselves.

Please describe medical device(s):

☐ Client will use a mobility device during their administration session and **requires assistance** to use the device(s). Client will complete a Client Support Person Plan.

☐ Client will use a mobility device during their administration session and **does not require assistance** to use the device(s) themselves.

Please describe mobility device(s):

☐ Client will use augmentative and alternative communication (AAC) device support or assistive listening device support during the administration session and **requires assistance** to use the device(s). Client will complete a Client Support Person Plan.

☐ Client will use augmentative and alternative communication (AAC) device support or assistive listening device support during the administration session and **does not require assistance** to use the device(s) themselves.

Please describe device(s):

☐ Client **requires assistance** to consume psilocybin products. Client will complete a Client Support Person Plan.

By signing this form, I acknowledge that I have reviewed and completed this Client Medication and Medical/Assistive form with a psilocybin services facilitator prior to participating in an administration session.

_____
Client Name (Print)

_____ _____
Client Signature Date

By signing this form, I acknowledge that I have reviewed and completed this Client Medication and Medical/Assistive form with the client prior to the client participating in an administration session.

_____
Facilitator Name (Print)

_____ _____
Facilitator Signature Date