Psychiatric Inpatient Medication Administration Record (MAR)

Patient Name: _____ **MRN:** _____

DOB: _____ **Allergies:** _____

Admission Date: _____ **Physician:** _____

Unit: _____ **Room #:** _____

SCHEDULED MEDICATIONS

Medication	Dosage	Route	Schedule	Start Date	End Date	Initials	Time Administered	Remarks

PRN (AS NEEDED) MEDICATIONS

Medication	Dosage	Route	Indication	Time Given	Initials	Patient Response	Remarks

NOTES

_____
Nurse Signature/Initials

_____
Date