*Date:*_____

Enter Member Name Here

Enter Member Address 1 Here

Enter Member Address 2 Here

Enter City Here State Zip

Dear _____,

Thank you for talking with me on _____, about your health and medications. As a follow-up to our talk, **I've included two lists**:

1. Your **Recommended To-Do List** has steps that you should take to get the best results from your meds.

2. Your **Medication List** will help you keep track of what you take and how to take it.

If you want to talk about these lists, please call
Enter MTM Provider/Department Name Here at

Enter MTM Provider/Plan, Phone, Days/Times, TTY etc. Here

I look forward to working with you and your doctors to make sure your meds work well for you.

Sincerely,

Enter MTM Provider Name Here

Enter MTM Provider Title Here

Enter Organization Name Here

Medications for Enter Member Name Here, DOB: _____

Recommended To-Do List

Prepared on: _____

You can get the best results from your medications by completing the items on this **"To-Do List."**

Bring your **To-Do List** when you go to your doctor. Be sure to share it with your family or others who care for you.

My To-Do List

TOPIC 1 **What we talked about:**	**TOPIC 1** **What action I should do:** ❑ _____ ❑ _____

TOPIC 2 **What we talked about:**	**TOPIC 2** **What action I should do:** ❑ _____ ❑ _____

TOPIC 3 **What we talked about:**	**TOPIC 3** **What action I should do:** ❑ _____ ❑ _____

TOPIC 4 What we talked about:	TOPIC 4 What action I should do: ❑ _____ ❑ _____

Medication List

Prepared on: _____

Bring your Medication List when you go to the doctor, hospital, or ER (emergency room). Be sure to share it with your family or others who care for you.

Note any changes to how you take your meds.
Cross out meds when you no longer use them.

Medication	How I take it	Why I use it	Prescriber (Doctor)
Enter medication name, strength and dose here.	Enter times you take your medications and any devices used that help you when you take your medications here.		

Medications for Enter Member Name Here, DOB: _____

Add new medications, over-the-counter drugs, herbals, vitamins, or minerals in the blank rows below.

Medication	How I take it	Why I use it	Prescriber (Doctor)

Allergies:

Side effects I have had:

Other information:

My notes and questions: