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 medication(s), 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 medication during their administration session and **requires assistance** to administer the medication. Client will complete a Client Support Person Plan.

☐ Client will take medication during their administration session and **does not require assistance** to administer the medication to themselves. Please list the medication(s):

☐ 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