St. Clair County Community Mental Health

Self-Administration of Medication (SAM) Assessment Tool

Individual: _____ Case #: _____ Residence: _____

Case Manager: _____

Use this assessment to evaluate the above-named individual's ability to participate in a self-medication program by placing a check in the appropriate boxes below, as well as providing comments when relevant.

Task	Yes/No	Support Needed	Comments
Responds when name is called	☐ Yes ☐ No	☐ Requires physical prompt or gesture. ☐ Other: _____	
Time concept recognition: ☐ am ☐ pm ☐ breakfast ☐ lunch ☐ dinner/supper ☐ bedtime ☐ day of the week	☐ Yes ☐ No	☐ Requires pictures to recognize correct time of day to receive medication. ☐ Other: _____	
Understands basic number concepts and is able to count from 1 to 3.	☐ Yes ☐ No	☐ Requires counter or assistance from staff. ☐ Other: _____	
Identifies different colors	☐ Yes ☐ No	☐ Requires picture to reference pill shape. ☐ Other: _____	
Discerns different shapes	☐ Yes ☐ No	☐ Requires picture to reference pill shape. ☐ Other: _____	
Identifies their name on medication bottle/drawer	☐ Yes ☐ No	☐ Requires special sticker/symbol to recognize personalized medication container. ☐ Other: _____	
Names medication(s) they receive	☐ Yes ☐ No	☐ Needs to write medication names to verify	
Knows correct dosage of medication	☐ Yes ☐ No	☐ Requires prompts	
Self-administers medication via correct route as ordered	☐ Yes ☐ No	☐ Requires prompts	
Opens and closes medication container	☐ Yes ☐ No	☐ Needs assistance	
Pours correct dosage of medication	☐ Yes ☐ No	☐ Needs assistance	
Obtains an adequate amount of medication	☐ Yes ☐ No	☐ Needs assistance	
Obtains adequate amount of fluid to take medication	☐ Yes ☐ No	☐ Needs assistance	

Based on this evaluation and observation, place a check on the appropriate box for recommendation:

☐	Individual is **not able** to administer medication to themselves at this time and **is not** recommended for the "Self-Administration of Medication" training program at this time.
☐	Individual is capable of self-administering medication with assistance and under close supervision and/or hands on assistance. The individual will participate in the medication administration and will start an individual training program.
☐	Individual has the potential to self-administer medication independently and safely. The individual is recommended by this staff to start an individual training program.

The Self-Administration of Medication Assessment must be completed at a minimum once a month or whenever there is a change in medication route, health status, functional status, etc.

_____ _____ _____

Assessing Staff Signature | Print Name | Date

Health-Medical Form: #04-0306
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EHR: Health Services, Other Health Docs Note: SAM Assessement