Sleep medication

Name: _____

Date	Is there medication specifically prescribed for its sleep-inducing effect?	Is a reduction possible?	Was it reduced?	Remarks	Duration of contact (min)	Name of responsible staff member
	☐ Yes, label: _____ _____ ☐ PRN, label: _____ _____	☐ Yes ☐ No ☐ No medication	☐ Yes ☐ No			
	☐ Yes, label: _____ _____ ☐ PRN, label: _____ _____	☐ Yes ☐ No ☐ No medication	☐ Yes ☐ No			
	☐ Yes, label: _____ _____ ☐ PRN, label: _____ _____	☐ Yes ☐ No ☐ No medication	☐ Yes ☐ No			