Participant Evaluation Form

Thank you for participating in today's Check Your Meds Day. Your opinion is important to us. Please complete this evaluation form and give to staff before leaving today. This will help us improve similar programs in the future and learn if today's medication review was helpful to you.

Date: _____

Participant #: _____

Location: _____

	Yes	No	I don't know
			
1. Was the medication review helpful to you?			
2. Was the information clear?			
3. Did you learn anything from today's session?			
4. Will you change the way you take your medications based on today's check-up?			
5. When you completed the medication review, did you understand the reason for taking each of your medications?			

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