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Talk to your doctor, nurse or pharmacist before making any changes to your medication.

Patient Name: _____ Doctor: _____ Medication: _____

Tapering Schedule

WEEK OF:	SU	MO	TU	WE	TH	FR	SA
1. ___/___	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>
2. ___/___	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>
3. ___/___	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>
4. ___/___	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>
5. ___/___	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>
6. ___/___	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>
7. ___/___	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>
8. ___/___	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>

What the symbols mean:

 Full dose _____
 Half dose _____
 Quarter of a dose _____
 No dose _____

Talk to your doctor, nurse or pharmacist before changing or stopping your medication.