3-Hole 1/4 1 3/8 c-to-c

OUTPATIENT MEDICATION RECONCILIATION

Allergies: Drug/Foods	Reactions/Side Effects

❑ Yes ❑ No Latex allergy or sensitivity?

If yes, describe type of reaction: ______________________________

❑ Yes ❑ No Are you allergic to iodine or radiocontrast agents?

❑ No Known Drug Allergies

❑ On No Medications at Home	❑ Liquid Meds Only	Local Pharmacy Phone
❑ Swallows pills	❑ Crushes pills	Unable to obtain Medication History Reason: ______________________________

Home and Current Medications on Admission (Prescriptions, OTC, Patches, Inhalers, Eye Drops, Vitamins & Herbal Supplements)					Physician Medication Orders on Admission (check Only One)		
Drug Name	**Dose**	**Route**	**Frequency**	**Last Taken Date/Time**	**Continue Medication**	**Do not Continue Medication**	**Change Medication**
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑

Data collection by RN ______________________________ Date/Time: ______________

Source of Information: ______________________________

☐ The treatment/procedure you received today **Will** **Not** change your current medications.

☐ The treatment/procedure you received today **Will** change your current medications/dose/schedule as follows:

Changes To Current Medications

____

____

____

____

New Prescriptions

____

____

____

____

Copy sent/faxed to ______________________________

M.D. Signature: ______________ Date/Time: ______________

Print Name: ______________

PATIENT IDENTIFICATION LABEL

White - Chart Yellow - Patient (to Pharmacy Dept. if admitted) Pink - Other

72481 6/07

3-Hole 1/4 1 3/8 c-to-c

OUTPATIENT MEDICATION RECONCILIATION

Allergies: Drug/Foods	Reactions/Side Effects

❑ Yes ❑ No Latex allergy or sensitivity?

If yes, describe type of reaction: ____________________

❑ Yes ❑ No Are you allergic to iodine or radiocontrast agents?

❑ No Known Drug Allergies

❑ On No Medications at Home	❑ Liquid Meds Only	Local Pharmacy Phone
❑ Swallows pills	❑ Crushes pills	Unable to obtain Medication History Reason: ____________________

Home and Current Medications on Admission (Prescriptions, OTC, Patches, Inhalers, Eye Drops, Vitamins & Herbal Supplements)					Physician Medication Orders on Admission (check Only One)		
Drug Name	Dose	Route	Frequency	Last Taken Date/Time	Continue Medication	Do not Continue Medication	Change Medication
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
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					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑

Data collection by RN ____________________ Date/Time: ____________________

Source of Information: ____________________

☐ The treatment/procedure you received today **Will** **Not** change your current medications.

☐ The treatment/procedure you received today **Will** change your current medications/dose/schedule as follows:

Changes To Current Medications

____
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____

New Prescriptions

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____
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Copy sent/faxed to ____________________

M.D. Signature: ____________________ Date/Time: ____________________

Print Name: ____________________

White - Chart Yellow - Patient (to Pharmacy Dept. if admitted) Pink - Other

PATIENT IDENTIFICATION LABEL

72481 6/07

5-Hole 1/4 1 3/8 c-to-c

OUTPATIENT MEDICATION RECONCILIATION

Allergies: Drug/Foods	Reactions/Side Effects

❑ Yes ❑ No Latex allergy or sensitivity?

If yes, describe type of reaction: ______________________

❑ Yes ❑ No Are you allergic to iodine or radiocontrast agents?

❑ No Known Drug Allergies

❑ On No Medications at Home	❑ Liquid Meds Only	Local Pharmacy Phone
❑ Swallows pills	❑ Crushes pills	Unable to obtain Medication History Reason: ______________________

Home and Current Medications on Admission (Prescriptions, OTC, Patches, Inhalers, Eye Drops, Vitamins & Herbal Supplements)					Physician Medication Orders on Admission (check Only One)		
Drug Name	**Dose**	**Route**	**Frequency**	**Last Taken Date/Time**	**Continue Medication**	**Do not Continue Medication**	**Change Medication**
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
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					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑

Data collection by RN ______________________ Date/Time: ______________________

Source of Information: ______________________

☐ The treatment/procedure you received today **Will** **Not** change your current medications.

☐ The treatment/procedure you received today **Will** change your current medications/dose/schedule as follows:

Changes To Current Medications

____
____
____
____

New Prescriptions

____
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____
____

Copy sent/faxed to ______________________

M.D. Signature: ______________________ Date/Time: ______________________

Print Name: ______________________

PATIENT IDENTIFICATION LABEL

White - Chart Yellow - Patient (to Pharmacy Dept. if admitted) Pink - Other

72481 6/07