MEDICATION RECONCILIATION

Allergies: _____ **□ Latex □ Tape □ Iodine □ No Known Drug Allergies**

Information Source: ☐Patient ☐Caregiver/Family☐ Other: _____ Unable to obtain due to ☐ Patient condition ☐ Patient's knowledge of meds

(Include all herbals, prescription, over the counter, eye drops, inhalers, vitamins and supplements)

DATE	Drug Name and Dosage	Route other than by mouth	How often taken each day	Started at this visit	Stop	Continue	Given on Discharge P=Prescription S=Samples

The listed medications are correct. I, the undersigned, have read and understand these instructions. I understand if prescriptions are to be filled, I will do this at the pharmacy of my choice. □ I have been provided with a copy of this form to give to my next care provider.

Signature of Patient or Authorized Representative: _____Date/Time:_____

Signature of Clinician Reviewing Discharge Instructions:_____ Date/Time:_____

Subsequent Patient Visits

I verify that I or my informant have reviewed the Out Patient Data Base dated _____(with a date within 30 days). All of the information is complete and correct and I have made all necessary revisions.

□ I have been provided with a copy of this form to give to my next provider of care

Signature of Patient or Authorized Representative: _____Date/Time:_____

Signature of Clinician Reviewing Discharge Instructions:_____ Date/Time:_____

□ I have been provided with a copy of this form to give to my next provider of care

Signature of Patient or Authorized Representative: _____Date/Time:_____

Signature of Clinician Reviewing Discharge Instructions:_____ Date/Time:_____

□ I have been provided with a copy of this form to give to my next provider of care

Signature of Patient or Authorized Representative: _____Date/Time:_____

Signature of Clinician Reviewing Discharge Instructions:_____Date/Time:_____