MEDICATION RECONCILLIATION

*Please write all medications and allergies on this form. Unfortunately attached lists cannot be accepted. Thank you

List all allergies/reactions to medications(prescription and over the counter),environmental, foods and latex

Allergy	Reaction	Verified by:

List all Prescription Drugs and Over-the-Counter Medications, Including Dietary Supplements, Vitamins & Herbal Medications

Please resume all medications as directed by the prescribing physician

Drug Name and Dose	Frequency	Reason for Medication

When can I have my next dose?

DRUG:	Reason for this medication:	TIME:

Your Physician may have provided you with a prescription you will need to fill. Further information regarding medication administration, side effects and /or adverse reactions will be provided by physician or dispensing pharmacy.

Discharge Medication- Doctor/Nurse Use Only (this is not a prescription)

Drug Name & Dose	Frequency	Reason for Medication

Patient or Guardian Signature ______________________ Date ______________________ Patient label

Discharge RN signature ______________________ Date ______________________