HOAG MEMORIAL HOSPITAL PRESBYTERIAN

OUT- PATIENT MEDICATION RECONCILIATION UPON ENTRY TO HOSPITAL

Date of Procedure/Visit: _____ Primary Care Physician (PCP): _____

Date: _____ Time: _____ PCP Phone #: _____

Acknowledgement: I confirm that this is a complete and accurate list of my (patient's) current medications, to the best of my knowledge, including prescription and over the counter drugs. I understand that healthcare providers will make medical decisions based on this information.

Name of person completing this form: _____

ALLERGIES: List all allergies to medications, herbs, food, latex, IV contrast, and other. Describe the reaction.
☐ None (Example: Sulfa – rash)

_____

_____

_____

CURRENT MEDICATIONS: List your prescriptions, herbal, and over-the-counter medicines you take.
☐ None ☐ Patient poor historian/No family present/Unable to obtain information at this time

Medication Name	Dose	Frequency	Reason	Upon Discharge Change in Regimen
				☐
				☐
				☐
				☐
				☐
				☐
				☐
				☐
				☐
				☐

Discharge – Additional Prescriptions and Specific Medication Instructions:
1.
2.
3.
4.
5.

PATIENT INSTRUCTIONS: Above is the list of medications you indicated that you are currently taking. Resume taking your current medications, noting any checked boxes which indicate a change in your current medication regimen. Remember to follow the new medication instructions as directed. All medication changes or new prescriptions will be relayed to your referring physician. Please contact the physician who prescribed your medications if you have any questions. Your signature below means you understand these instructions.

_____ _____ _____ A.M./P.M.
[Patient/Legal Representative] [Date] [Time]

_____ _____ _____ A.M./P.M.
[MD or Authorized Staff] [Date] [Time]

MEDICATION RECONCILIATION ADDENDUM

Date: ______________________ Medication list reviewed with patient. ☐ No Change ☐ Change* (see front)

Signature: ______________________
[MD or authorized staff]

Date: ______________________ Medication list reviewed with patient. ☐ No Change ☐ Change* (see front)

Signature: ______________________
[MD or authorized staff]

Date: ______________________ Medication list reviewed with patient. ☐ No Change ☐ Change* (see front)

Signature: ______________________
[MD or authorized staff]

Date: ______________________ Medication list reviewed with patient. ☐ No Change ☐ Change* (see front)

Signature: ______________________
[MD or authorized staff]

Date: ______________________ Medication list reviewed with patient. ☐ No Change ☐ Change* (see front)

Signature: ______________________
[MD or authorized staff]

Date: ______________________ Medication list reviewed with patient. ☐ No Change ☐ Change* (see front)

Signature: ______________________
[MD or authorized staff]

Date: ______________________ Medication list reviewed with patient. ☐ No Change ☐ Change* (see front)

Signature: ______________________
[MD or authorized staff]

* Any deletion in medication please line through on front.
* Any additions in medications please write on front.