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.

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose</th>
<th>Frequency</th>
<th>Reason</th>
<th>Upon Discharge</th>
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</table>

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.

_________________________________  ____________  __________

[Patient/Legal Representative]  [Date]  [Time]

_________________________________  ____________  __________

[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]

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