HOAG HOSPITAL USE ONLY:

☐ ***FAX to Pharmacy after admit physician signs***

PATIENT STATED HOME MEDICATION LIST

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. BRING THIS FORM WITH YOU TO HOAG.

☐ ***Check this box if not on any home medications.***

_____ _____

DESCRIBE ALLERGIES & REACTIONS: [Signature of Patient/Responsible Person]

Completed by: _____ Date/Time: _____

Source of Medication History: _____

Physician Orders on Hoag Admit: Continue or Formulary Equivalent (circle one)		Medication	Dose	Route	Freq	Reason for Taking	Dose last taken - RN to Complete	On Discharge: Stop	On Discharge: Continue (Next Dose)
Y	N	1.							
Y	N	2.							
Y	N	3.							
Y	N	4.							
Y	N	5.							
Y	N	6.							
Y	N	7.							
Y	N	8.							
Y	N	9.							
Y	N	10.							

Medication Reconciliation on Entry:

_____ Noted: ☐ CC/RN: _____ Date/Time: _____

[Physician Signature] ☐ RN: _____ Date/Time: _____

Date/Time: ID#:

DATE TIME T/O FROM SIGNATURE/TITLE

Medication Reconciliation on Discharge:

_____

[Physician Signature]

Date/Time: ID#:

DISCHARGE: PRINT NEW MEDICATIONS AND CHANGES TO ABOVE MEDICATIONS (PROVIDE PRESCRIPTION TO PATIENT)

Medication	Dose	Route	Freq	Reason	Special Instructions	Medication Schedule				Comments:

Original to patient on discharge. Line through stopped meds.

Discharge RN: _____

Date/Time:

Discharge Physician Signature: _____

Date/Time: ID#:

DATE TIME T/O FROM SIGNATURE/TITLE

MEDICATION RECONCILIATION/ORDERS
Hoag Memorial Hospital Presbyterian

PS 7514 Rev 12/16/10

[2517]

PLACE IN FRONT OF PHYSICIAN ORDERS

Original – Patient Photocopy 1 – Chart Photocopy 2 – Primary Care Physician

Page ____ of ____ Patient Name _____