MEDICATION RECONCILIATION FORM

Name:	**DOB:**

Drug Allergies/ Describe Reaction:

LIST BELOW ALL OF THE PATIENT'S MEDICATIONS PRIOR TO ADMISSION INCLUDING OVER-THE-COUNTER AND HERBAL MEDS

NAME OF MEDICATION/DOSE	*ROUTE/FREQUENCY*	*DATE STOPPED*	*REASON/MD NAME*	*DATE RE-STARTED*

NEW MEDICATIONS ADDED

DATE	*NAME OF MEDICATION/DOSE*	*ROUTE/FREQUENCY*	*REASON*	*MD NAME*

Source of Medication List:
__ Patient Medication List
__ Patient/Family Recall
__ Pharmacy:_____
__ Primary Care Physician List
__ Previous Discharge Paperwork

Reviewed:
Date:_____ By:____ **Date:_____ By:____**
Date:_____ By:____ **Date:_____ By:____**
Date:_____ By:____ **Date:_____ By:____**
Date:_____ By:____ **Date:_____ By:____**

___ THIS IS AN ADDENDUM TO OR REVISION OF PREVIOUSLY COMPLETED MED LIST