



OUTPATIENT 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

Table with 5 columns: Medication Name, Dose, Frequency, Reason, and Upon Discharge Change in Regimen. Includes checkboxes for each medication row.

- 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 Signature: Date: Time: A.M./P.M.

Medication list reviewed with patient. No Change

MD or Authorized Staff Signature: Date: Time: A.M./P.M.