COOKEVILLE REGIONAL MEDICAL CENTER

# MEDICATION RECONCILIATION

| Sources of Information (check all applicable): |
|---|
| ❑ Patient's own medication list/supply |
| ❑ Patient/Family recall |
| ❑ Pharmacy (name and phone): |
| ❑ Physician's list (name): |
| ❑ Transferring facility records (facility name): |
| ❑ Other (specify): |

| ALLERGIES | REACTIONS |
|---|---|
| ___ | ___ |
| ___ | ___ |
| ___ | ___ |
| ___ | ___ |
| ___ | ___ |
| ___ | ___ |

**Medication History Recorded By:** ______________________ **Date:** __________ **Time:** __________

*LIST BELOW ALL OF THE PATIENT'S MEDICATIONS (ORAL, TOPICAL, PARENTERAL, ETC.) PRIOR TO **ADMISSION** AND **DISCHARGE** INCLUDING OTC, HERBAL MEDICATIONS, AND VITAMINS. NEW MEDICATIONS OR MEDICATION CHANGES SHOULD BE WRITTEN ON ADMISSION/ DISCHARGE ORDERS.*

| PHY. ONLY ADMISSION DATE | MEDICATION NAME | DOSE | ROUTE (PO, IV, TOP, etc.) | FREQ | LAST DOSE DATE / TIME | PHY. ONLY DISCHARGE DATE |
|---|---|---|---|---|---|---|
| C DC | 1. | | | | | C DC |
| C DC | 2. | | | | | C DC |
| C DC | 3. | | | | | C DC |
| C DC | 4. | | | | | C DC |
| C DC | 5. | | | | | C DC |
| C DC | 6. | | | | | C DC |
| C DC | 7. | | | | | C DC |
| C DC | 8. | | | | | C DC |
| C DC | 9. | | | | | C DC |
| C DC | 10. | | | | | C DC |
| C DC | 11. | | | | | C DC |
| C DC | 12. | | | | | C DC |
| C DC | 13. | | | | | C DC |
| C DC | 14. | | | | | C DC |
| C DC | 15. | | | | | C DC |

C = Continue DC = Discontinue

**ADMISSION:**

______________________________

MD Signature Date/Time

**IF SIGNED, RECONCILIATION FORM WILL BE CONSIDERED ORDERS**

PATIENT ID STICKER

**DISCHARGE:**

❑ **FOLLOW UP WITH PRIMARY CARE PHYSICIAN FOR HOME MEDICATIONS**

**NEW MEDICATIONS AND/OR DOSAGE CHANGES AT DISCHARGE:**

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

______________________________

MD Signature Date/Time

**IF SIGNED, RECONCILIATION FORM WILL BE CONSIDERED ORDERS**