



MEDICATION RECONCILIATION FORM

Source of Medication List (check all used):

- Patient
- Family Member / Guardian / Caregiver
- Primary Care Physician List
- NO KNOWN ALLERGIES - NKA** (medication, food or environment)

DO NOT USE ABBREVIATIONS

U, IU, QD, QOD, trailing zero (1.0), lack of leading zero (.1),
MS, MSO4, MgSO4, ug, AU, OS, OD,

	ALLERGIES (Medication & Food)	REACTION
1		
2		
3		

PLEASE PRINT

	Medication List: OTC, Herbals Vitamins & Supplements	DOSE (Strength)	HOW TAKEN?	FREQUENCY (How often taken)	LAST TIME TAKEN?	HOLD	NO
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							

Medication History Verified by RN: _____ Date/Time _____

IN ADDITION TO THE PRESCRIPTIONS BELOW, THE ABOVE MEDICATIONS SHOULD BE CONTINUED AT HOME UNLESS SPECIFIED BY		
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%; background-color: #e0e0e0; padding: 5px;"> SIGNATURE OF SURGEON REVIEWING MEDICATIONS: (REQUIRED) </td> <td style="border: 1px solid black; height: 30px;"></td> </tr> </table>	SIGNATURE OF SURGEON REVIEWING MEDICATIONS: (REQUIRED)	
SIGNATURE OF SURGEON REVIEWING MEDICATIONS: (REQUIRED)		

Prescriptions Given to Patient Upon Discharge					
	MEDICATION NAME	DOSE	ROUTE	FREQUENCY	Reason for Medication
1					
2					
3					

Information provided to (circle one): **Patient** **Other:** _____
(Name of person)

Discharge RN Signature: _____

Date: _____ **Time:** _____