



Medication Reconciliation Form

Member Name:			DOB:
Admit Date:	Disch Date:	Review Date:	Facility:

MEDICATION(S) PRIOR TO ADMISSION

List all Medications – Nutritional/ herbals supplements, over the counter medications, pumps or patches used prior to this visit or admission.

Source: Patient Family D/C Instructions Other _____

Medication (include strength)	Directions (dose, Route, Freq)	Indication (Reason)	Last Dose (Date/Time)	Resume Meds on Disch?
<i>Example: Aspirin 81mg.</i>	<i>1 tablet orally every day</i>	<i>Heart</i>	<i>12/30/07 8am</i>	[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				Y N

You may safely continue **ONLY** the medications circled “Y” above.
If you have any questions, please contact your primary care physician.

ADDITIONAL PRESCRIPTIONS GIVEN AT DISCHARGE:

Medication (include Strength)	Dose/ Route/ Frequency	Indication	Next Dose (Date/Time)	Start date
1				
2				
3				
4				
5				
6				

Noted by: _____ Clinician Reconciled by: _____ MD

- Fax to PCP
- Copy to Member

FAX BACK MD SIGNED FORM TO (909) 623-0753