Little River HealthCare
Temple Surgery Center

MEDICATION RECONCILIATION ORDER FORM

Patient's Name _____ **Date of Birth** _____

Height _____ **Weight:** _____ kg ☐ **Breastfeeding** ☐ **Pregnant**

Allergies and Reactions: ☐ **NO KNOWN ALLERGIES**

_____

_____

Name of person filling out this form:

_____

Source of Information: ☐ Patient ☐ Family ☐ Physician Office ☐ H & P ☐ Med Bottles ☐ Unable to Obtain ☐ Other _____

LIST HOME MEDICATIONS BELOW: Lay Terms Only, No Abbreviations

Include over the counter meds, inhalers, eye drops

Did you take this AM?	Medication (Include Strength/Dose/Route/Frequency) Non-formulary supplements and herbals should be documented	Last Dose	Reason for taking medication	Discharge: Continue at home unless checked	
Y☐ N☐				No ☐	
Y☐ N☐				No ☐	
Y☐ N☐				No ☐	
Y☐ N☐				No ☐	
Y☐ N☐				No ☐	
Y☐ N☐				No ☐	
Y☐ N☐				No ☐	
Y☐ N☐				No ☐	
Y☐ N☐				No ☐	
Y☐ N☐				No ☐	

☐ No New Medication **NEW OR CHANGED MEDICATION AT DISCHARGE**

(Please bring this medication record with you to your next physician office visit.)

Prescription given?	Medication (Include Strength/Dose/Route/Frequency)	Next Dose	Other Instructions/Reason For Taking
Y☐ N☐			
Y☐ N☐			
Y☐ N☐			
Y☐ N☐			
Y☐ N☐			

Physician Signature: _____ **Date/Time:** _____

Patient Signature: _____ **Date/Time:** _____

Nurse Signature: _____ **Date/Time:** _____

Disclaimer: You may continue the home medications listed above unless checked "no". This list was made with the assumption that the information given by you (or the person you came in with) is complete and accurate. If you have questions about any of the home medications, please contact the doctor who prescribed them.

White copy-Patient at discharge Yellow copy-Medical record