SIBLEY MEMORIAL HOSPITAL
PATIENT MEDICATION LIST

PATIENT LABEL

PATIENT OR FAMILY: Please list all medications you are currently taking. Include all prescription medications, over the counter medications, supplements, eye drops, and or herbals.

Person Completing Form (print name): ______________________ **Relationship to Patient:** ______________

☐ **No Medications** ☐ **Unable to obtain history, reason:**

☐ **No Known Allergies**	**List Allergies to drugs and reaction, food and reaction, and if allergic to latex:** ______________________

Vaccine/other History: Check (√) all vaccines received and list date if known. ☐ **Vaccine history not known**

☐ Pneumonia vaccine/Date: ☐ Influenza vaccine/Date: ☐ Rhogam/Date:

MEDICATION NAME: ***(WRITE LEGIBLY)*** **Attach to form:** ☐ **Patient list** ☐ **Facility list**	**Dose** (mg, mcg, other)	**Route** (oral, other)	**Frequency** (how often)	**Last Dose** (date/time)

FOR HOSPITAL USE ONLY

Information Source (circle): Patient Family MD List Container Pharmacy EMS Other:

For any updates, complete and attach additional PATIENT MEDICATION LIST

List Reviewed by (print name): ______________________ Date: __________ Time: __________

MEDICATIONS AT DISCHARGE: *OUTPATIENT ONLY*

PATIENT TO BRING THIS COPY OF INSTRUCTIONS TO NEXT PROVIDER

☐ **Copy of medication prescriptions placed in medical record, originals to patient**

New medication at discharge, change in prior medication prescribed, or special instructions:

Medication	**Dose**	**Route**	**Frequency**	**Instructions, if applicable**

Patient/Family/Power of Attorney

Signature: ______________________ **Date/Time:** __________

Nursing

Signature: ______________________ **Date/Time:** __________

Physician/LIP/Pharmacist

Signature/Authentication: ______________________

Date: __________ **Time:** __________

02446MR (09/09)