## MEDICATION RECONCILIATION

Allergies:			🗆 Latex 🗆 Tape	e 🗆 Iodine	□ No K	nown	n Drug Allergies	
nformation Source	e: □Patient □Caregiver/Family□ Other: _		ble to obtain due to ☐ Patient co			vledge (	of meds	
DATE	(Include all herbals, prescript  Drug Name and Dosage	Route	nter, eye drops, inhalers, vita How often taken	Given on D			Given on Discharge P=Prescription	
DATE		other than by mouth	each day	Started at this visit	Stop	Continue	S=Samples	
	cations are correct. I, the undersigned, lee pharmacy of my choice.   I have been						are to be filled, I	
ignature of Pat	gnature of Patient or Authorized Representative:  gnature of Clinician Reviewing Discharge Instructions:				*			
_		Subsequer	nt Patient Visits					
nformation is	r my informant have reviewed the Ocomplete and correct and I have mad	e all necessary r	evisions.	(with a c	date withi	n 30 d	lays). All of the	
I have been provided with a copy of this form to give to my next provider of care ignature of Patient or Authorized Representative:				Date/Time:				
ignature of Cli	nician Reviewing Discharge Instruction rovided with a copy of this form to give	ns:			Date/	Time:		
ignature of Pat	ient or Authorized Representative:		idei di care		Date/	Γime:_		
ignature of Cli I have been pi	nician Reviewing Discharge Instruction ovided with a copy of this form to give	to my next provi	ider of care		Date/			
ignature of Pat	ient or Authorized Representative:nician Reviewing Discharge Instruction				Date/	Γime:_ Time:		
ignature or CII	moran reviewing Discharge moduction	10				· 1111C		

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