

## MEDICATION RECONCILIATION LIST

ALLERGY (DRUG)	REACTION	ALLERGY (DRUG)	REACTION
<input type="checkbox"/> - NKDA			

### Current Prescriptive Medications, Herbals, Vitamins, Supplements, Non-Prescriptive Drugs

MEDICATION(S)	HOW OFTEN	LAST TAKEN	MAY RESUME
<input type="checkbox"/> - None			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
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			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

### New Medications or New Dosages you should take after discharge

MEDICATION	HOW OFTEN	START

Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Nurses Signature: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

