

MEDICATION RECONCILIATION

STAT "PLACE X IN BOX IF STAT"

"Authorization is hereby given to dispense the Generic equivalent or Medical Staff approved therapeutic equivalent unless otherwise indicated by the words – **DO NOT SUBSTITUTE - MEDICAL NECESSITY**"

NO HOME MEDICATIONS AT ADMISSION

ALLERGIES: NKA YES

DRUG: _____ PAGE _____ OF _____

OTHER: _____

HOME MEDICATION RECONCILIATION/ORDERS

LIST OBTAINED FROM: Patient Family Written List Prescription Bottle Pharmacy **Nurse:** _____ **Date:** _____

Patient/Family sure unsure about medications

HOME MEDS					DISCHARGE	
DRUG	DOSAGE/ROUTE	FREQUENCY	PATIENT'S HOME TIMES	LAST DOSE	STOP	CONTINUE

DISCHARGE CHANGES OR ADDITIONS

DRUG	DOSAGE / ROUTE	FREQUENCY	PATIENT'S HOME SCHEDULE	PRESCRIBED FOR

PLEASE KEEP THIS MEDICATION LIST AND TAKE THIS LIST TO EACH OF YOUR DOCTOR/HOSPITAL VISITS

Daily – once a day	PO – take by mouth	HS – at bedtime
TID – three times a day	BID – twice a day	SL – under the tongue
AC – before meals	QID – four times a day	

Discharge Date: _____ Time: _____

Physician Signature: _____

Fax to office: _____

[COPY TO PATIENT AT DISCHARGE]



SWEETWATER

ANGIOGRAPHY CENTER

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PATIENT IDENTIFICATION: