❍ Admission ❍ Transfer
❍ Readmission ❍ Discharge

MEDICATION RECONCILIATION FORM

INSTRUCTIONS: Complete upon admission, readmission, transfer or discharge for verification of resident medication orders to prevent adverse drug events.

Primary Care Physician:________________________ Phone:________________ Fax:________________
Pharmacy:________________________ Phone:________________ Fax:________________
Caregiver:________________________ Relationship:________________ Phone:________________

Allergies/Reactions:____
____
Comments:____
____
____

Vaccinations: (date of last immunization)
Influenza:________________ Pneumococcal:________________

Medical Conditions:
❑ Asthma ❑ Heart disease ❑ Diabetes ❑ High blood pressure
❑ Cancer ❑ Kidney disease ❑ Other:________________

RECORD ALL PRESCRIPTION, OVER-THE-COUNTER, HERBAL AND INHALATION MEDICATIONS (Includes Oxygen, CPAP, Nebulizer, BiPAP)

Medication	Strength	Dose	Route	Frequency	Time of Last Dose	Check Box to Identify Field Discrepancy					Medication Discrepancy Resolution Contact				Resolved		If Not Resolved, Contact Was Made to:			
						Med.	Strength	Dose	Route	Freq.	RN Hospital	MD/Phys Extender	Family	Phar-macy	No	Yes	RN	Shift	MD	Other (specify)
					❍ AM ❍ PM	❑	❑	❑	❑	❑	❑	❑	❑	❑	❍	❍	❑		❑	
					❍ AM ❍ PM	❑	❑	❑	❑	❑	❑	❑	❑	❑	❍	❍	❑		❑	
					❍ AM ❍ PM	❑	❑	❑	❑	❑	❑	❑	❑	❑	❍	❍	❑		❑	
					❍ AM ❍ PM	❑	❑	❑	❑	❑	❑	❑	❑	❑	❍	❍	❑		❑	
					❍ AM ❍ PM	❑	❑	❑	❑	❑	❑	❑	❑	❑	❍	❍	❑		❑	
					❍ AM ❍ PM	❑	❑	❑	❑	❑	❑	❑	❑	❑	❍	❍	❑		❑	
					❍ AM ❍ PM	❑	❑	❑	❑	❑	❑	❑	❑	❑	❍	❍	❑		❑	
					❍ AM ❍ PM	❑	❑	❑	❑	❑	❑	❑	❑	❑	❍	❍	❑		❑	
					❍ AM ❍ PM	❑	❑	❑	❑	❑	❑	❑	❑	❑	❍	❍	❑		❑	
					❍ AM ❍ PM	❑	❑	❑	❑	❑	❑	❑	❑	❑	❍	❍	❑		❑	
					❍ AM ❍ PM	❑	❑	❑	❑	❑	❑	❑	❑	❑	❍	❍	❑		❑	
					❍ AM ❍ PM	❑	❑	❑	❑	❑	❑	❑	❑	❑	❍	❍	❑		❑	
					❍ AM ❍ PM	❑	❑	❑	❑	❑	❑	❑	❑	❑	❍	❍	❑		❑	
					❍ AM ❍ PM	❑	❑	❑	❑	❑	❑	❑	❑	❑	❍	❍	❑		❑	
					❍ AM ❍ PM	❑	❑	❑	❑	❑	❑	❑	❑	❑	❍	❍	❑		❑	
					❍ AM ❍ PM	❑	❑	❑	❑	❑	❑	❑	❑	❑	❍	❍	❑		❑	
					❍ AM ❍ PM	❑	❑	❑	❑	❑	❑	❑	❑	❑	❍	❍	❑		❑	

Reconciliation Completed By (Signature/Title):________________________ Date:____________ Time:__________ ❍ AM ❍ PM

NAME–Last	First	Middle	Attending Physician	DOB	Record No.	Room/Bed

MEDICATION RECONCILIATION FORM

COMMENTS

NAME–Last	First	Middle	Attending Physician	DOB	Record No.	Room/Bed