COMPLETE THE YELLOW SHADED COLUMNS FIRST!
THEN REMOVE THE TOP COPY OF THE FORM TO COMPLETE THE REMAINING INFORMATION.

ALLERGIES:

Home Medications **Dose / Route/ Frequency** (Include Herbal/OTC/Vitamins)	**Indication**	**Continue Medication On Admission?**	
Patient takes no medications ☐			
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No

IMMUNIZATION RECORD (Record the **month/year** of last dose taken, if known)

Pneumonia Vaccine:	Flu Vaccine(s):	Other:

Information obtained:

☐ *Patient/Family* ☐ *Bottles/List* ☐ *Old Records* ☐ *Retail Pharmacy* ☐ *MD Office Records* ☐ *Unable to Obtain*

Comments:

PHYSICIAN SIGNATURE: _____ DATE: _____ TIME: _____

Patient Label

ADMISSION MEDICATION RECONCILIATION FORM

Please bring this medication record with you to your physician's office and/or upon return to the hospital.

Medication/Dose/How to Take/How Often (Include Herbal/OTC/Vitamins)	Reason for Medication	Continue Same Medication?	
Took no medications on admission ☐			
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No

ALLERGIES:

IMMUNIZATION RECORD (Record the month/year of last dose taken, if known)

Pneumonia Vaccine:	Flu Vaccine(s):	Other:

Home Medication Information On Admission Obtained:

☐ *Patient/Family* ☐ *Bottles/List* ☐ *Old Records* ☐ *Retail Pharmacy* ☐ *MD Office Records* ☐ *Unable to Obtain*

NEW MEDICATION RECORD

Medication / Dose / How to Take / How Often	Reason for Medication

Physician Signature:	Date/Time:	Nurse Signature:	Date/Time:

Patient Label

PATIENT DISCHARGE MEDICATION LIST