MEDICATION RECONCILIATION
ADMISSION / DISCHARGE FORM/ORDERS
(Includes herbals, OTC Meds, vitamins, nutraceuticals)

Patient ID Label

Information obtained from: ☐ Patient ☐ Nursing Home ☐ Previous Admission ☐ History and Physical ☐ Family ☐ Other
☐ Copied from patient's Labeled Medications ☐ Obtained from patient's pharmacy:_____
☐ Patient and verified medication list Personal Meds: ☐ Sent home with:_____ ☐ Sent to Pharmacy Department

Medication Name: Strength/Dosage/Form/Frequency Patient is knowledgeable about home meds? ☐Yes ☐ No	**Continue in Hospital**	**Continue at Discharge**
1)	☐ Yes ☐ No	☐ Yes ☐ No
2)	☐ Yes ☐ No	☐ Yes ☐ No
3)	☐ Yes ☐ No	☐ Yes ☐ No
4)	☐ Yes ☐ No	☐ Yes ☐ No
5)	☐ Yes ☐ No	☐ Yes ☐ No
6)	☐ Yes ☐ No	☐ Yes ☐ No
7)	☐ Yes ☐ No	☐ Yes ☐ No
8)	☐ Yes ☐ No	☐ Yes ☐ No
9)	☐ Yes ☐ No	☐ Yes ☐ No
10)	☐ Yes ☐ No	☐ Yes ☐ No
11)	☐ Yes ☐ No	☐ Yes ☐ No
12)	☐ Yes ☐ No	☐ Yes ☐ No
13)	☐ Yes ☐ No	☐ Yes ☐ No
14)	☐ Yes ☐ No	☐ Yes ☐ No
15)	☐ Yes ☐ No	☐ Yes ☐ No

Hospital Pharmacy Order: Compare Pre-Admission Medications with Formulary Medications. Formulary medications that are identical in form and content may be substituted while in hospital. EXCEPT, for the following meds:	1)_____ 2)_____ 3)_____ 4)_____	**do NOT substitute**

Height:	**Weight: ☐ Actual ☐ Stated**	**☐ No Known Drug Allergies** **Allergies:**

Vaccination Decision (Risk Assessment completed on admission)

☐ **Pneumococcal vaccine**	☐ **Indicated**	☐ **Not Indicated**	☐ **Administer vaccine per protocol**
☐ **Influenza vaccine**	☐ **Indicated**	☐ **Not Indicated**	☐ **Administer vaccine per protocol**

☐ **Continue medications as listed ABOVE with the following ADDITIONAL discharge medications orders:**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

ADMISSION RECONCILIATION	**DISCHARGE RECONCILIATION/ORDER**
Nurse Signature **Date/Time:**	**Nurse Signature** **Date/Time:**
☐ **Reviewed** **Physician Signature:** **Date/Time:**	**Physician Signature** **Date/Time:**

I have reviewed with the nurse and understand my home medications. (To be signed at discharge)
Pt Signature/other and relationship/Date/Time: