



## Medication Reconciliation Form

Source of info:  Patient    Med Bottles    Family    List    Physician Office    Pharmacy    Other

Allergies and Reactions: \_\_\_\_\_

List all prescription, over-the-counter, vitamins and herbal/natural medications taken routinely	Dosage	Frequency	De'd Prior to Surgery	Last Dose	Continue upon discharge	Discontinue	Check with PCP	Comments

Patient/Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Signature of Nurse obtaining original list: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Unless otherwise indicated, please resume medications which have been prescribed to you when you return home.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Signature of Nurse discharging patient: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_