Medication Reconciliation & Order Form

MISSION: LOCATION:

PATIENT INFORMATION

Patient Name (Last, First, MI)	Patient ID #	Birth Date	Sex (*circle one*)	Height (ft & in)	Weight (kg)
			Male Female		

ALLERGY INFORMATION: **No known *drug* allergy** **No known *food* allergy** **Latex** **Tape** **Dye** **Contrast**

Drug/Food/Other	Reaction	Drug/Food/Other	Reaction	Drug/Food/Other	Reaction

INFORMATION OBTAINED FROM/BY

Chief Complaint / Diagnosis (*if known*)	Information taken by (*name*)	Medication/other information is provided by (*check below*) on date: _____
	_____ RN/APRN PA RPh MD/DO *(circle one)* _____ Other (*describe*)	Patient Prescription Bottles Medication List Prescription (*doctor name/phone*): _____ Family (*relationship/adult or minor*): _____ Physician office (*name/phone*): _____ Pharmacy (*name/phone*): _____ Other (*describe*): _____

PATIENT'S OVER-THE-COUNTER MEDICATIONS USAGE AND PAST MEDICAL / FAMILY HISTORY

OTC USE: *Conditions in which patients may use OTC drugs*

Headache	Heartburn/GI upset/gas	Eye/ear problems
Cold/flu	Diarrhea	Muscle/joint pain
Sinus/congestion	Constipation	Rash/itching/dry skin
Allergies	Hemorrhoids	Acne
Cough	Weight loss	Insect bite/poison ivy
Sleeplessness	Smoking cessation	Ear care

Other (describe: _____)

PAST MEDICAL & FAMILY HISTORY: *mark all that apply*

	Self	Relative		Self	Relative
Alcoholism	☐	☐	Mental illness	☐	☐
Stroke	☐	☐	Diabetes	☐	☐
Asthma	☐	☐	Kidney disease	☐	☐
Hypertension	☐	☐	Heart disease	☐	☐
Cancer	☐	☐	Liver disease	☐	☐
Depression	☐	☐	Lung disease	☐	☐

Other conditions (describe: _____)

HOME MEDICATION REGIMEN: **Not on medication(s) at home** **Unable to obtain medication history** (reason:)

PRESCRIPTION, OVER-THE-COUNTER MEDICATION, HERBAL, and SUPPLEMENTS HISTORY – within 1 year

Order now	Stop order	Change order		Medication(s) - Strength	Directions			PRN	Duration	Indication	Date Last Filled	Date/Time Last Taken
					Dose	Route	Freq					
			WRITE NEW MEDICATION ORDER(S) BELOW									

NEW MEDICATION ORDER(S): including CII – CV unless a triplicate is required by a particular state

Medication(s) - Strength	Directions			PRN	Duration	Indication	Refill #	Prescribed by: MD, DO, PA, ARNP, RPh	Verbal order taken by: RN, RPh
	Dose	Route	Freq						

Pharmacist (PRINT): _____ Signature: _____ Date Rx Filled/Checked: _____