MEDICATION RECONCILIATION

PATIENT NAME: DATE OF BIRTH:

PHARMACY NAME: **PHONE:**

****Please complete this record. Please list all medications prescribed by a physician as well as any over the counter medication, supplements, and vitamins you take regularly. ****

Please list current drug allergies and their reaction

ALLERGY/REACTION	ALLERGY/REACTION
	.

MEDICATION	DOSE	ROUTE	FREQUENCY	INDICATION	DATE LAST TAKEN
.					

Medication information given by patient and recorded by :_____

Medication Reconciliation Verified by RN : _____ Date/Time: _____