



PREADMISSION MEDICATION LIST

(Medication Reconciliation)

Please include all prescription drugs, herbal product, dietary supplement and over-the-counter medication use.

Source of Medication list: (check all used)

- Patient medication list
- Patient/Family recall
- Pharmacy _____
- Primary care physician _____
- Previous discharge paperwork (date _____ facility _____)
- Medication Administration Record from facility (facility _____)
- Other: _____

Patient Name _____

Unit _____

Patient MRN _____

Allergies _____

Date _____ Time _____

Drug Name & Strength (Must be complete! Ex. Adderall vs Adderall XR, Depakote vs. Depakote ER, etc)	Dose (in mg, mcg, etc.)	Route*	Frequency	Indication	Date & Time of Last Dose	How long has pt been on this medication & dose?	How often does Patient miss doses? (Daily/ Weekly/ Never)	On Admission:		Continue upon discharge: Yes OR No	Nurse Initial: Transfer medications to Discharge Medication Reconciliation form upon discharge
								C = Continue	DC = Discontinue		
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*Oral route assumed unless otherwise noted

Name of Patient's Pharmacy: _____ City: _____ Phone #: _____

If questionable, medications/doses/compliance issues verified with local pharmacy? Yes No N/A By _____

Comments: _____

For medications that are not to be continued upon admission, please note rationale:

Medication to be discontinued	Rationale

Medication to be discontinued	Rationale

Medication history recorded by: _____ Date/time: _____

Reviewed and transcribed to physician's order:

RN Signature

Date/Time

MD Signature

Date/Time