1. Allergies and Reaction: ☐ No Known Allergies or ____

____

Food Allergies: ☐ No Known Allergies or ____

Include topicals, ointments, liquids, parenterals, oxygen, inhalers, drops, over the counter medications, herbals & vitamins

Provider Only **Check Meds to be continued while in the Hospital** ☐N/A-Outpatient	**2. Medication Name**	**Dosage** (Also include any variables. For example 15mg 1-2 tabs)	**Route** (by mouth, injection, topical, inhalation, IV, etc…)	**Frequency** (How often?)	**Indication** (What does the patient take the medication for?)	***Pre-Op Only*** **Date/Time of Last Dose** *(to be done on date of surgery)*	***Provider Only*** **On Discharge** Check Meds to be Continued at Home
❒ Y ❒ N							❒ Y ❒ N
❒ Y ❒ N							❒ Y ❒ N
❒ Y ❒ N							❒ Y ❒ N
❒ Y ❒ N							❒ Y ❒ N
❒ Y ❒ N							❒ Y ❒ N
❒ Y ❒ N							❒ Y ❒ N
❒ Y ❒ N							❒ Y ❒ N
❒ Y ❒ N							❒ Y ❒ N
❒ Y ❒ N							❒ Y ❒ N
❒ Y ❒ N							❒ Y ❒ N
❒ Y ❒ N							❒ Y ❒ N
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❒ Y ❒ N							❒ Y ❒ N
❒ Y ❒ N							❒ Y ❒ N
❒ Y ❒ N							❒ Y ❒ N
❒ Y ❒ N							❒ Y ❒ N
❒ Y ❒ N							❒ Y ❒ N
❒ Y ❒ N							❒ Y ❒ N
❒ Y ❒ N							❒ Y ❒ N

3. Source of Information: ☐ No home medications ☐ Patient

☐ Medication List ☐ Patient's Family ☐ Medication bottles ☐ Old Chart

☐ Nursing Home ☐ Doctor's Office ☐ Pharmacy ☐ Other: ________________

4. Medication History Initiated By: ________________________________ Date/Time: ______________

5. ***Physician/PA/ARNP Signature***:____________________________ Date/Time:______________________

6. Medication History Updated by: ________________________________ Date/Time: ______________

Medication History Updated by: ________________________________ Date/Time: ______________

☐ List sent to Pharmacists.

7. Additional Home Medications for Patient Discharge. To be completed by hospital staff at discharge

Use more than one form if necessary to complete discharge meds

Medication	Dose/Route/Frequency/Comments	Next Dose?	Rx Given?
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N

8. ☐ ***Copy given to patient or significant other by***: Date/Time:

OneCore Health Orthopedic Hospital

Medication History/Reconciliation Form

Place patient label here. If not available, complete:

Patient Name:

DOB:

DOS:

Revised 1/2009, 5/28/09, 3-4-10, 6/14,12/14