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 cont'd while in Hospital with overnight stay	**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?)	*Nursing Only* Validated with Pharmacy or Bottles Inpt Only	*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
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☐Y ☐N								☐Y ☐N
☐Y ☐N								☐Y ☐N
☐Y ☐N								☐Y ☐N

3. Source of Information:

☐ Medication List

☐ Nursing Home

☐ No home medications

☐ Patient's Family

☐ Doctor's Office

☐ Patient

☐ Medication bottles

☐ Pharmacy

☐ Old Chart

☐ Other: ____________________

4. Medication History Initiated By: ______________________________ Date/Time: ________________

5. Physician Signature: ______________________________ Date/Time: ________________

6. Medication History Updated by: ______________________________ Date/Time: ________________

Medication History Updated by: ______________________________ Date/Time: ________________

☐ Medications have been identified appropriately by inpatient nursing staff *(Inpatients only)*

☐ 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

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

OneCore Health

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, 3/15, 7/15, 9/16, 4/17