MEDICATION RECONCILIATION

Allergies:			🗆 Latex 🗆 Tape	□ Iodine	□ No K	nown	Drug Allergies
nformation Sour	rce: □Patient □Caregiver/Family□ Other:		ble to obtain due to □ Patient co			vledge (of meds
DATE	(Include all herbals, prescrip Drug Name and Dosage	Route other than by mouth	nter, eye drops, inhalers, vitan How often taken each day	Started at this visit this visit	Stop Gements)	Continue	Given on Discharge P=Prescription S=Samples
vill do this at this at the ignature of Pa	Lications are correct. I, the undersigned, I he pharmacy of my choice. I have been tient or Authorized Representative: I have been tient or Authorized Representative: I have been tient or Authorized Representative:	n provided with a		my next care	e providerDate/	Γime:_	ire to be filled, I
_	or my informant have reviewed the O	Subsequen	t Patient Visits	(with a			
nformation is	complete and correct and I have made	e all necessary r	evisions.	(with a (iau Willi	11 JV U	ays). An of the
☐ I have been provided with a copy of this form to give to my next provider of care lignature of Patient or Authorized Representative:				Date/Time: Date/Time:			
I have been p	provided with a copy of this form to give	to my next provi	der of care				
ignature of Cl	tient or Authorized Representative:inician Reviewing Discharge Instruction	s:			Date/1	i ime:_ Time:_	
ignature of Pa	provided with a copy of this form to give tient or Authorized Representative:		der of care		Date/	Гіте:_	
ignature of Cl	inician Reviewing Discharge Instruction	s:			Date/	Time:	

BAYLOR UNIVERSITY MEDICAL CENTER MARTHA FOSTER LUNG CARE CENTER OUTPATIENT DATABASE INFORMATION Page 3 of 3