☐ STAT

**Outpatient Medication Reconciliation** 

**#CHPCS098 Revised 10/11**

# Outpatient Medication Verification

Please use ball point pen and press hard to go through carbon.

**Are you allergic to any medications, products or foods? ☐ No ☐ Yes If yes, please complete the box below:**

| ALLERGIC TO: | REACTION(S) | ALLERGIC TO: | REACTION(S) | ALLERGIC TO: | REACTION(S) |
|---|---|---|---|---|---|
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*LIST BELOW ALL OF THE PATIENT'S HOME MEDICATIONS INCLUDING OTC AND ALTERNATIVE MEDS*

**PROHIBITED ABBREVIATIONS: qd, qod, U, IU, .X, X.0, MS, MSO4, MgSO4, µg, SS**

Source of Medication list: (check all used)

- ☐ Patient medication list
- ☐ Patient/Family recall
- ☐ Pharmacy ________________
- ☐ Primary care physician list / PCHIS
- ☐ Previous discharge paperwork
- ☐ Medication Administration Record from facility
- ☐ Other: ______________________________

☐ Pregnant? ☐ Breastfeeding?

MEDICATION HISTORY RECORDED/VERIFIED WITH PATIENT PRIOR TO THE PROCEDURE BY: ________________________________________

DATE RECORDED: ______________

| MEDICATION NAME (WRITE LEGIBLY) | DOSE (mg, mcg) | ROUTE (PO, GT, Sub-Q, IV) | HOW OFTEN | LAST DOSE DATE/TIME | Post-Procedure Cont | Post-Procedure Stop |
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**Continue all medications unless indicated otherwise above**

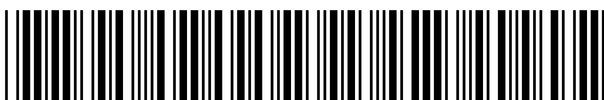
☐ If changes in long term meds or addition to long term meds then copy faxed to PCP: ______________________

Prescriptions given for : ____________________________________________

Reviewed on Discharge and copy given to patient

Signature: __________________________ Printed Name: _________________________ Date/Time: ____________

Scan to pharmacy following discharge of patient.




Patient Label

White – Medical Record Yellow – Patient