



<b>PATIENT LABEL</b>
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## 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)

*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)

- |   |   |
|---|---|
| <input type="checkbox"/> Patient medication list<br><input type="checkbox"/> Patient/Family recall<br><input type="checkbox"/> Pharmacy _____<br><input type="checkbox"/> Primary care physician list / PCHIS | <input type="checkbox"/> Previous discharge paperwork<br><input type="checkbox"/> Medication Administration Record from facility<br><input type="checkbox"/> 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	Stop

**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: \_\_\_\_\_

Fax to pharmacy following discharge of patient.