

Allergies/Reactions: _____

Patient's Community Pharmacy: _____ Phone Number: _____

HOME MEDICATION LIST

**IF ADDITIONAL SPACE IS NEEDED, PLEASE USE A SECOND COPY OF HOME MEDICATIONS LIST.*

CONTINUE IN HOSPITAL? (ORDERS MUST BE WRITTEN)			<input type="checkbox"/> NO HOME MEDICATIONS	DOSE	ROUTE	FREQUENCY <i>(Do Not Use "Unsafe Abbreviations")</i>	DISCHARGE MEDICATIONS	
Yes	ORDERED	No					Resume at Same Dose	DO NOT Resume at Discharge to Home
			PRESCRIPTION MEDICATIONS / OVER-THE-COUNTER / VITAMIN SUPPLEMENTS					
			1.					
			2.					
			3.					
			4.					
			5.					
			6.					
			7.					
			8.					
			9.					
			10.					
			11.					
			12.					
			13.					
			14.					
			15.					
			16.					
			17.					

ADMISSION NURSE SIGNATURE		DATE	DISCHARGE NURSE SIGNATURE		DATE

SIGNATURE BELOW INDICATES MEDICATIONS HAVE BEEN RECONCILED

ADMISSION PHYSICIAN SIGNATURE	PHYSICIAN #	DATE	DISCHARGE PHYSICIAN SIGNATURE	PHYSICIAN #	DATE

THIS IS NOT A PHYSICIAN ORDER FORM

LEE MEMORIAL HEALTH SYSTEM
 Lee County, Florida
HOME MEDICATION RECONCILIATION LIST
 FM# 3414-A 3/06
 Linked to Policies: M02 01 110, M03 03 563
UCO TAB - PHYSICIAN ORDERS

ADMISSION INSTRUCTIONS:

- A. **Nurse** completes accurate and current list of home medications.
- B. **Provider** reviews list on initial patient rounds and writes all medication orders on the physician order sheet.
- C. **Provider** dates and signs form indicating medications reconciled on admission.