☐ Check here if this is an addendum or a revision of a previously completed medication list

MEDICATION RECONCILIATION FORM

☐ SOC ☐ ROC ☐ D/C ☐ Recert ☐ SCIC ☐ Other________

PATIENT NAME: ____________________

Allergy: ☐ NKDA ☐ Food: ____________________

☐ Medications: ____________________

☐ Other: ____________________

Primary Pharmacy Name: ____________________ Phone: ____________________

☐ Check here if patient is using more than 1 pharmacy

New = less 30 days; **Changed** = within 60 days; **Old** = existing medication

Problem(s) Identified:
(If present, use # below:)

- ☐ 1. Potential Adverse Effects
- ☐ 2. Ineffective Drug Therapy
- ☐ 3. Significant Side Effects
- ☐ 4 Significant Drug Interactions
- ☐ 4. Duplicative Drug Therapy
- ☐ 5. Non-Compliance with Drug Therapy

Date_______Initial_____Prob#:______
Date_______Initial_____Prob#:______

Legend:
Medication Information Source:

1. Rx Bottle/Script
2. Recent In-patient D/C Instruction/ MAR
3. Pt med list ALF
4. PCP (Verbal)
5. Patient (Verbal)
6. Family/Caregiver (Verbal)
7. Other__________

HOME PRESCRIPTIONS + OTC + HERBAL MEDICATIONS

(N) New (C) Changed (O) Old	Medication Name (Capitalized)	Dose	Frequency (Layman's Term)	Route (Layman's Term)	Date Last Dose (If applicable)	Purpose/Classification (If medication is also self-prescribed, check box [SP])	Medication Information Source (Use Legend Above)	Medication Disposition 1- At Home 2- Not Bought
						☐ SP		
						☐ SP		
						☐ SP		
						☐ SP		
						☐ SP		
						☐ SP		
						☐ SP		
						☐ SP		
						☐ SP		
						☐ SP		
						☐ SP		
	☐ Home Oxygen							

Medication Reconciled By: ____________________ ☐ No Problems Identified
Signature/Title

Date of Review: ____________

Review Date: ________ Signature : ________	☐ No Problems Identified	Review Date: ________ Signature : ________	☐ No Problems Identified	Review Date: ________ Signature : ________	☐ No Problems Identified

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(WHITE COPY- Office; YELLOW COPY- Patient; PINK COPY- Clinician)