



Outpatient Procedures
Med Reconciliation Form /
Discharge Instructions

Signature of Person Completing Form: _____

MUST FILL OUT COMPLETE MEDICATION LIST PRIOR TO START OF TREATMENT

[] The patient is unable to provide a list of medication(s), there is not family or other individual(s) who can provide the list, and the patient's pharmacy is unknown or unavailable (initial box if applicable and sign above)

Patient Allergies/Reactions/Sensitivities: _____
(including food and environmental allergies)

Table with 6 columns: Drug Name, Dose, Directions (Route / Frequency), Last Taken Date / Time, Indications, May Resume. Header: Home Medications on Admission (Include Prescription, OTC/Herbals/Vitamins, Patches, Inhalers, etc)

PHYSICIAN MUST SIGN
ATTESTATION BELOW

PHYSICIAN
ATTESTATION
Unless otherwise noted, the
patient's list of home
medications has been
reviewed and has been
compared to those
medications that will be
ordered.

[] Patient may resume pre-
op medications per ordering
physician.

MD Signature / time

Date: «Appt_Date»

Patient must read and sign the
discharge instructions below.

MD will note any changes to
current medications.

New medications prescribed to you today: _____

DISCHARGE INSTRUCTIONS:

Above is a list of medications that you have indicated you are currently taking. Unless otherwise noted below, you should resume taking these medications. Please contact the physician who prescribed your medications if you have any questions. In addition, any medication that has been prescribed as a result of your visit has been noted as well. Please notify your primary care physician of any additions and/or changes to your medications. Your signature below means you understand these instructions.

Signature of Patient/Responsible Party _____ Date: «Appt_Date»