LINCOLN SURGERY ENDOSCOPY SERVICES

Medication Reconciliation Form

Please include all prescription, over-the-counter, vitamins and herbal/natural medications taken routinely prior to admission.

Data source: ☐ Patient ☐ Family ☐ MD ☐ Old Records

Patient's Pharmacy: (if applicable) _____ Phone #: _____

Allergies & Reaction: _____

☐ Not taking home medications

Names of Medication (Include Herbal, OTC & Vitamins)	Dose	Frequency (How Often)	Route (oral, inj, patch)	Indication (Why taking medication)	Last Dose Taken		Completed for Discharge	
					Time	Date	Resume Med	D/C Med

Nurse obtaining/reviewing original list: _____ Date: _____

Please list new medications prescribed for patient at discharge.				
Medications	Dose	Route	Frequency	Notes

Physician's signature: _____ Date: _____

Medication changes reviewed with patient or caregiver. Copy given to patient or caregiver.

Discharge Nurse's signature: _____ Date: _____

Responsible Party signature: _____ Date: _____

Patient: Please share this information with your pharmacist when filling new prescriptions.

Patient Label

Chart - White Copy
Patient - Yellow Copy