

MR#:

DOB: / /

?

## MEDICATION RECONCILIATION REPORT OB & OUTPATIENT AREAS

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Source of Information:

DOB: \_\_\_\_\_

Patient

Medication Allergies:

Family member

Other

NOT TAKING ANY MEDICATIONS

PREGNANT

BREASTFEEDING

Are you on any antibiotics in preparation for this procedure?  No  Yes, if so include on list below

**LIST ALL MEDICATIONS YOU ARE TAKING,  
INCLUDING OVER-THE-COUNTER AND HERBAL MEDICATIONS**

MEDICATION	DOSE	ROUTE	FREQUENCY	COMMENTS	CONTINUE	DISCONTINUE
<b>NEW MEDICATION/CHANGES TO MEDICATIONS FOLLOWING THIS VISIT:</b>						

\_\_\_\_\_  
Admission RN Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Discharge RN Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

