RR DONNELLEY

HIGHLAND HOSPITAL
STRONG MEMORIAL HOSPITAL

MEDICATION RECONCILIATION

SH 2000 MR
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Rev 1/11

Source of Medication List (check all that apply)
- ☐ Patient
- ☐ Family
- ☐ Parent/Guardian
- ☐ PCP
- ☐ Other Provider
- ☐ Pharmacy
- ☐ Medical Record
- ☐ Medication List
- ☐ Medication Containers
- ☐ Other: _____

Patient Instructions: Please complete all non-shaded areas. **Provider Instructions:** Please complete remainder of the form.

☐ No Known Allergies ☐ Latex allergy

Allergy	Reaction	Allergy	Reaction

Weight: _____ (kg) Height/Length: _____ (cm)

Is patient pregnant? ☐ Yes ☐ No

Is patient breast feeding? ☐ Yes ☐ No

☐ Patient is taking no medications at home. ☐ Unable to obtain medication history. Reason:

Medication Name	Strength & Form	Dose	Weight-Based Dosing (patients <40kg)	Route	Frequency	Indication	Last Dose Taken	Pre-Procedure Reconciliation	Post-Procedure Reconciliation

C=Continue
H=Hold for procedure
M=Modify
D=Discontinue

C=Continue
R=Resume on _____
N=New
D=Discontinue

If needed, continue medication list on reverse side of form.

Signatures:

Patient/Parent/Legal Guardian's Name Printed: _____ Signature: _____ Date & Time: _____

Pre-procedure
Nurse's Name Printed: _____ Signature: _____ Date & Time: _____
Provider's Name Printed: _____ Signature: _____ Date & Time: _____

Post-procedure
Nurse's Name Printed: _____ Signature: _____ Date & Time: _____
Provider's Name Printed: _____ Signature: _____ Date & Time: _____

Patient Name: _____ MR#: _____

Medication Name	Strength & Form	Dose	Weight-Based Dosing (patients <40kg)	Route	Frequency	Indication	Last Dose Taken	Pre-Procedure Reconciliation	Post-Procedure Reconciliation

C=Continue
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M=Modify
D=Discontinue

C=Continue
R=Resume on _____
N=New
D=Discontinue

Signatures:

Patient/Parent/Legal Guardian's Name Printed: _____ Signature: _____ Date & Time: _____

Pre-procedure Nurse's Name Printed: _____ Signature: _____ Date & Time: _____

Provider's Name Printed: _____ Signature: _____ Date & Time: _____

Post-procedure Nurse's Name Printed: _____ Signature: _____ Date & Time: _____

Provider's Name Printed: _____ Signature: _____ Date & Time: _____