

M Northwestern Memorial[®] Hospital

Diagnostic and Therapeutic Procedures Medication Reconciliation Form

Dear Patient,
Please complete the following. A staff member will review this list and update it as needed.

ALLERGIES: Please check none or list allergies below: None

Source	Reaction	Source	Reaction
<i>Example: Penicillin</i>	<i>Hives</i>	2.	
1.		3.	

MEDICATION Names of all medications you are taking including over the counter medicines, vitamins, minerals or herbal supplements.	STRENGTH List the strength of each tablet, capsule, etc.	DOSE How much are you taking? (number of tablets, capsules, units, etc.)	FREQUENCY How often do you take the medication? (once a day, twice a day, etc.)	ROUTE How are you taking this medication? (by injection, patch, etc.)	LAST DOSE TAKEN Indicate the date and time of the last dose taken.
<i>Example: Cardizem CD</i>	<i>180 mg</i>	<i>1 capsule</i>	<i>once a day</i>	<i>by mouth</i>	<i>9 am today</i>

Do not write below this line - Hospital Staff ONLY!

Discharge Instructions:

The medications you were taking prior to your treatment(s) have been reviewed.

Based on your treatment today, there should be no changes to your home medications. If you have any questions about your present medications, please contact your primary care physician.

Before taking the following medications you must contact your physician and have blood work drawn:

Other medication instructions: _____

Comments: _____

Staff Signature: _____ Date: _____

Patient Signature: _____ Date: _____