RECONCILIATION OF HOME MEDICATIONS OUTPATIENT SERVICES FORM

ALLERGIES: ❑ **No known allergies**

Source of Home Medication Information:
❑ Patient's own medication list ❑ Patient / Family member ❑ Physician's list ❑ Other: ____________________

Do not use	U or u	Qd, q.d., Q.D. or QD	Qod, QOD Q.O.D.	Trailing zero (X.0. mg)	Lack of leading zero (.Xmg)	$MgSO_4$	MS MSO_4	I.U. or IU
Approved for use	**Units**	**Daily**	**Every other day**	**"X" mg**	**"0.X" mg**	**Magnesium sulfate**	**Morphine sulfate**	**International unit**

HOME MEDICATION LIST

1. Include all prescription, over the counter, vitamin, and herbal products
2. Draw a line thru any item that has been stopped with the date in the last column
3. Write in NEW or CHANGED items below the last entry listed

DATE	MEDICATION NAME (Please print)	DOSE (how many milligrams)	ROUTE (orally, etc)	HOW OFTEN IS THE PRODUCT TAKEN ?	DATE LAST TAKEN "UNK" if unknown	DATE STOPPED OR CHANGED
	☐ **Takes NO home medications**					
				_______ (# of times daily) ❑ PRN for:		
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				_______ (# of times daily) ❑ PRN for:		

Date	Reviewer Signature / emp#	Action taken	Copy sent/given to:	
		❑ No change in therapy ❑ changes indicated	❑ Patient ❑ Next provider of care	❑ Patient refused to provide information
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