HOAG HOSPITAL USE ONLY:

☐ ***FAX to Pharmacy after admit physician signs***

PATIENT STATED HOME MEDICATION LIST

Acknowledgement: I confirm that this is a complete and accurate list of my (patient's) current medications, to the best of my knowledge, including prescription and over the counter drugs. I understand that healthcare providers will make medical decisions based on this information. **BRING THIS FORM WITH YOU TO HOAG.**

☐ ***Check this box if not on any home medications.***

(Signature of Patient/Responsible Person)

DESCRIBE ALLERGIES & REACTIONS:

Physician Orders on Hoag Admit

Completed by: _____ Date/Time: _____

Source of Medication History: _____

Continue or Formulary Equivalent	Medication	Dose	Route	Freq	Reason for Taking	On Discharge: Stop	On Discharge: Continue (Next Dose)
	1.						
	2.						
	3.						
	4.						
	5.						
	6.						
	7.						
	8.						
	9.						
	10.						

Medication Reconciliation on Entry:

_____ Noted: ☐ CC/RN: _____ Date/Time: _____

(Physician Signature) ☐ RN: _____ Date/Time: _____

Date/Time: ID#:

DATE TIME T/O FROM SIGNATURE/TITLE

Medication Reconciliation on Discharge:

_____

(Physician Signature)

Date/Time: ID#:

DISCHARGE: PRINT NEW MEDICATIONS AND CHANGES TO ABOVE MEDICATIONS (PROVIDE PRESCRIPTION TO PATIENT)

Medication	Dose	Route	Freq	Reason	Special Instructions	Medication Schedule	Comments:

Original to patient on discharge. Line through stopped meds.

Discharge RN: _____

Date/Time:

Discharge Physician Signature: _____

Date/Time: ID#:

DATE TIME T/O FROM SIGNATURE/TITLE

MEDICATION RECONCILIATION/ORDERS
Hoag Memorial Hospital Presbyterian

PS 7514 05/16/08

[2517]

PLACE IN FRONT OF PHYSICIAN ORDERS

Original – Patient Photocopy 1 – Chart Photocopy 2 – Primary Care Physician

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