

UNIT NUMBER:

# PREADMISSION MEDICATION LIST VERIFICATION AND ORDER FORM (Medication Reconciliation)

Allergies:

*LIST BELOW ALL OF THE PATIENT'S MEDICATIONS PRIOR TO ADMISSION INCLUDING OTC AND HERBAL MEDS  
NEW MEDICATIONS OR MEDICATION CHANGES SHOULD BE WRITTEN ON ADMISSION ORDERS*

Source of Medication list: (check all used)

- Patient medication list
- Patient/Family recall
- Pharmacy \_\_\_\_\_
- Primary care physician list / PCHIS
- Previous discharge paperwork
- Medication Administration Record from facility
- Other:

**CHECK HERE IF THIS IS AN ADDENDUM TO OR REVISION OF PREVIOUSLY COMPLETED MEDICATION LIST**

*CIRCLE C to continue OR  
DC to discontinue*

MEDICATION HISTORY RECORDED/VERIFIED BY: \_\_\_\_\_

DATE RECORDED: \_\_\_\_\_

MEDICATION NAME (WRITE LEGIBLY)	DOSE (mg, mcg, )	ROUTE (PO, GT, SC, IV)	FREQUENCY	LAST DOSE DATE/TIME	PHYSICIAN ORDER		COMPLETE On Discharge
					Continue on Admission	Continue on Transfer	
1.					C	DC	C DC
2.					C	DC	C DC
3.					C	DC	C DC
4.					C	DC	C DC
5.					C	DC	C DC
6.					C	DC	C DC
7.					C	DC	C DC
8.					C	DC	C DC
9.					C	DC	C DC
10.					C	DC	C DC
11.					C	DC	C DC
12.					C	DC	C DC
13.					C	DC	C DC
14.					C	DC	C DC
15.					C	DC	C DC

Do not scan or take off orders without MD/NP/PA signature

**M.D. Signature:** \_\_\_\_\_ **Print Name:** \_\_\_\_\_

**Pager:** \_\_\_\_\_ **Date/Time:** \_\_\_\_\_

Reviewed and Transcribed

**Nurse Signature:** \_\_\_\_\_ **Date/Time:** \_\_\_\_\_