

## OUTPATIENT MEDICATION RECONCILIATION FORM

### Allergies

Type	Yes	No	List/Describe reaction	Reaction: R = Rash D = Difficulty breathing G= GI upset
Medication				
Food				
Environmental				
Latex Products				
Allergy Band				

### List of Patient's Current Medications

On **NO** medications at home

Name of Medication <small>Include prescription, over-the-counter, samples, vitamins, vaccines, herbal products, respiratory treatments, parenteral nutrition, and any other FDA substance listed as a drug</small>	Dose	Frequency	Reason for Taking	
			<small>Required for inpatient admission or if relevant and necessary to care provided in outpatient settings</small>	
1.				
2.				
3.				
4.				
5.				
6.				
7.				
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11.				
12.				
13.				
14.				
15.				
16.				
17.				

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Staff Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

