

PATIENT STATED HOME MEDICATION LIST

HOAG HOSPITAL USE ONLY:
 FAX to Pharmacy after admit physician signs

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.

DESCRIBE ALLERGIES & REACTIONS: _____ [Signature of Patient/Responsible Person]

Physician Orders on Hoag Admit	Completed by: _____ Date/Time: _____					On Discharge	
Continue or Formulary Equivalent	Source of Medication History: _____					Stop	Continue (Next Dose)
	Medication	Dose	Route	Freq	Reason for Taking		
	1.						
	2.						
	3.						
	4.						
	5.						
	6.						
	7.						
	8.						
	9.						
	10.						

Medication Reconciliation on Entry: _____ Noted: <input type="checkbox"/> CC/RN: _____ Date/Time: _____ <small>[Physician Signature]</small> Date/Time: _____ ID#: _____ <small>DATE TIME T/O FROM SIGNATURE/TITLE</small>	Medication Reconciliation on Discharge: _____ <small>[Physician Signature]</small> Date/Time: _____ ID#: _____
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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#: _____ <small>DATE TIME T/O FROM SIGNATURE/TITLE</small>
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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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