### ALLERGIES:

<table>
<thead>
<tr>
<th>Home Medications</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose/Route/Frequency</td>
<td>Indication</td>
<td>Initials</td>
</tr>
<tr>
<td>(Include Herbal/OTC/Vitamins)</td>
<td></td>
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</tbody>
</table>

**DATE**

**Patient takes no medications**

---

**Information obtained from:**

- ✅ Patient/Family
- ✗ Bottles/List
- ✗ Old Records
- ✗ Retail Pharmacy
- ✗ MD Office Records
- ✗ Unable to Obtain

☐ The medications listed above should not be changed based on the treatment you have received. If you have any questions, notify the prescribing physician.

**OR**

☐ Make the following changes to the medications you are taking:

---

**PHYSICIAN SIGNATURE:** ____________________________

**DATE:** ____________

**TIME:** ____________

---

**OUTPATIENT/ED MEDICATION RECONCILIATION FORM**

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**Chart copy**
1. Patient reports no medication changes since previous visit

OR

2. Additions/Deletions have been made since previous visit (see update on front of sheet).
   Contact physician to review changes and obtain orders, as indicated.

Clinician Signature: ____________________________

Date: ____________________________

3. Patient reports no medication changes since previous visit

OR

4. Additions/Deletions have been made since previous visit (see update on front of sheet).
   Contact physician to review changes and obtain orders, as indicated.

Clinician Signature: ____________________________

Date: ____________________________

5. Patient reports no medication changes since previous visit

OR

6. Additions/Deletions have been made since previous visit (see update on front of sheet).
   Contact physician to review changes and obtain orders, as indicated.

Clinician Signature: ____________________________

Date: ____________________________

7. Patient reports no medication changes since previous visit

OR

8. Additions/Deletions have been made since previous visit (see update on front of sheet).
   Contact physician to review changes and obtain orders, as indicated.

Clinician Signature: ____________________________

Date: ____________________________

9. Patient reports no medication changes since previous visit

OR

10. Additions/Deletions have been made since previous visit (see update on front of sheet).
    Contact physician to review changes and obtain orders, as indicated.

Clinician Signature: ____________________________

Date: ____________________________

11. Patient reports no medication changes since previous visit

OR

12. Additions/Deletions have been made since previous visit (see update on front of sheet).
    Contact physician to review changes and obtain orders, as indicated.

Clinician Signature: ____________________________

Date: ____________________________

SIGN-OFF FOR UPDATE(S) PERFORMED ON FRONT OF SHEET

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Patient Label

OUTPATIENT/ED MEDICATION RECONCILIATION FORM

Chart copy
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**Information obtained from:**
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- [ ] Retail Pharmacy
- [ ] MD Office Records
- [ ] Unable to Obtain

- The medications listed above should not be changed based on the treatment you have received. If you have any questions, notify the prescribing physician.

**OR**

- Make the following changes to the medications you are taking:

---

**Physician Signature:**

**Date:**

**Time:**

Please bring this medication record with you to your physician's office and/or upon return to the hospital.

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**Patient Medication List**

**Patient copy**