Medication Reconciliation Form

Client Name: ______________________________________ DOB: __________________________ Wt.: ______________(lbs/kg)

Known Allergies: ____ MRP: __________________________PH#___________________

A Best Possible Medication History (Medication Profile) is obtained when initiating care, when transferring to another service, when returning from another service, and periodically during service as needed.

Reason for Medication Reconciliation:

Admission to Resource Ability	☐	**Date:**	**Time:**	
Update During Service	☐	**Discharge from Resource Ability**	☐	
Transfer to another service/hospital	☐			
Return from another service/hospital	☐			

	Medication	**Dose**	**Route**	**Frequency**	**Taken as ordered**	**Comments**
1.					Yes ☐ No ☐	
2.					Yes ☐ No ☐	
3.					Yes ☐ No ☐	
4.					Yes ☐ No ☐	
5.					Yes ☐ No ☐	
6.					Yes ☐ No ☐	
7.					Yes ☐ No ☐	
8.					Yes ☐ No ☐	
9.					Yes ☐ No ☐	
10.					Yes ☐ No ☐	
11.					Yes ☐ No ☐	
12.					Yes ☐ No ☐	

****Physicians please note: this form is for information only and is not intended to be signed as Nursing orders or an active prescription. ****

Nurses Signature: ____ **Date**: ____________________________________

Revised Mar 2022