

Date: _____ Time: _____ Height: _____ Weight: _____ Smoking: Yes No Page 1 of _____

Pregnant Yes _____ weeks gestation No Breastfeeding: Yes No

MEDICATION INFORMATION

No medications taken at home
 Unable to obtain medication list
Reason: _____ Initials: _____

Information obtained from: (Check all that apply)

Patient Caregiver Medication List Brought in
Other: _____

Medications from home given to: Sent Home
 Locked at bedside Locked/Nurses Station

Medication changes in the last 7 days: _____

Allergies: Medications, food, nuts, shellfish, environmental, etc.

Allergic Reactions:

Flu Vaccine Yes No Date: _____

Pneumonia Vaccine Yes No Date: _____

Short Stay Patient

Patient converted to Inpatient

MEDICATIONS TAKEN AT HOME:

Include Prescriptions, Over-the-Counter, Herbs, Patches, Inhalers, Eye Drops, Samples, Medicated Lotions and Vitamins/Supplements

PHYSICIAN ORDERS

Medication Name	Dose (mg. units)	Route	Frequency	Last Dose Date/Time	Admission			Discharge			Indications/Comments
					Cont.	Stop	Chan	Cont.	Stop	Chan	
Example Medication	10mg	<input checked="" type="checkbox"/> by mouth <input type="checkbox"/> topical	Before meals PRN	04/02/05 0730	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GI symptoms
		<input type="checkbox"/> by mouth <input type="checkbox"/> topical			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/> by mouth <input type="checkbox"/> topical			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/> by mouth <input type="checkbox"/> topical			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/> by mouth <input type="checkbox"/> topical			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/> by mouth <input type="checkbox"/> topical			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/> by mouth <input type="checkbox"/> topical			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/> by mouth <input type="checkbox"/> topical			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/> by mouth <input type="checkbox"/> topical			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/> by mouth <input type="checkbox"/> topical			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/> by mouth <input type="checkbox"/> topical			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/> by mouth <input type="checkbox"/> topical			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/> by mouth <input type="checkbox"/> topical			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Medication continued on additional page

_____ Interviewer's Signature	_____ Date	_____ Time
_____ Admission Physician Signature	_____ Date	_____ Time
_____ Discharge Physician's Signature	_____ Date	_____ Time

Please bring this medication record with you to your physician office or on return to the hospital.

BAYLOR MEDICAL CENTER AT FRISCO
Medication Reconciliation Physician Orders