

HOME MEDICINE LIST – OUTPATIENT SERIES/CLINIC
 (MEDICATION RECONCILIATION)

ALLERGIES (Medicine, food, iodine) and describe reaction	<input type="checkbox"/> No Known Allergies

<u>Date/Initials</u>	<u>Medicine Name</u> <small>Include prescriptions, over the counter medicines, herbals, vitamins</small>	<u>Dose</u> <small>How many mg, mcg?</small>	<u>How Often?</u> <small>Once a day, before meals</small>	<u>Comments or Changes</u> <small>Patient's Pharmacy Phone # _____</small>
	<input type="checkbox"/> Patient takes no home medicines		<input type="checkbox"/> Every day <input type="checkbox"/> __times a day <input type="checkbox"/> As needed <input type="checkbox"/> Other _____	
			<input type="checkbox"/> Every day <input type="checkbox"/> __times a day <input type="checkbox"/> As needed <input type="checkbox"/> Other _____	
			<input type="checkbox"/> Every day <input type="checkbox"/> __times a day <input type="checkbox"/> As needed <input type="checkbox"/> Other _____	
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			<input type="checkbox"/> Every day <input type="checkbox"/> __times a day <input type="checkbox"/> As needed <input type="checkbox"/> Other _____	

GHS Associate Use at Each Visit:

Date/Initials	Time	Signature of GHS Associate Reviewing Home Medicines

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If this visit resulted in a medication change, fax form to the next provider(s) and give a copy to the patient.

Date	Next Provider	Fax Number

Date	Next Provider	Fax Number

