SAINT JOSEPH MERCY HEALTH SYSTEM
A Member of Trinity Health

❑ ST. JOSEPH MERCY ANN ARBOR
❑ ST. JOSEPH MERCY LIVINGSTON
❑ ST. JOSEPH MERCY SALINE
❑ ST. JOSEPH MERCY WOODLAND HEALTH CENTER

Medication Reconciliation Form

Name: _____ Date of Birth: _____ Height: _____ Weight: _____

Name of Family Physician _____ City _____ Physician Phone #_____

List all Prescription medications. Pre-procedural (Lovenox, antibiotics, pain) Over-the-counter (eye drops, antacids, laxatives), Nutritional & Herbal supplements, Pumps or Patches you are presently using

❑ **NO MEDICATIONS**

Name of Medication	Dose	Route (mouth, injection, inhaler)	How Often & When	RN ONLY Last Dose Taken (Date/Time)	INSTRUCTIONS After you leave
Insulin Pump Basal Rate					

❑ **NO KNOWN ALLERGIES**

ARE YOU ALLERGIC TO:	**Yes**	**No**			**Yes**	**No**	
Latex				Adhesive Tape?			
Foods				Other			
Iodine on your skin?							

LIST MEDICATION ALLERGIES BELOW

Medication Allergies	Reaction	Medication Allergies	Reaction	Medication Allergies	Reaction

Patient or Care Provider Signature:_____ Date: _____ Time: _____

Reviewed by:_____ RN Date: _____ Time: _____

Unless otherwise indicated above, you can resume the home medications listed.

I have reviewed this patient's home medication list and have taken it under consideration with regard to the medications currently prescribed for this patient.

Reviewed by:_____MD/DO/AHP Date: _____ Time: _____

PRESCRIPTIONS GIVEN AT DISCHARGE ❑ **NONE**

Medication	Dose	Route	Frequency	Indication	Last Dose

If you have any questions, contact your primary surgeon / primary physician.
**Please bring this medication record with you to your physican office or on return to the hospital **

Reviewed by: _____ RN

Date: _____ Time: _____ ❑ Copy given to patient

❑ Form sent to next care provider ❑ Unknown Provider / Given to Patient