MCG Health, Inc.

Medication Reconciliation -- Home Medication List **[patient label]**

Today's date _____

Date, Interviewer Initials	List all medications to which patient is allergic:	How severe is the reaction? Severe	Moderate	Mild	Unknown	Reaction
	☐ **No Known Drug Allergies**					

List all medications including prescription, over-the-counter, herbals or "natural remedies" and periodic in-office injections

Date, Interviewer Initials	Medication	Dosage	How often?	Reason Taken (optional)	Continue as Inpatient? (check)
					☐Yes☐No
					☐Yes☐No
					☐Yes☐No
					☐Yes☐No
					☐Yes☐No
					☐Yes☐No
					☐Yes☐No
					☐Yes☐No
					☐Yes☐No
					☐Yes☐No
					☐Yes☐No
					☐Yes☐No
					☐Yes☐No
					☐Yes☐No
					☐Yes☐No
					☐Yes☐No
					☐Yes☐No

☐ **Does not currently take any medications.**

Reviewed med list with patient and/or family ☐**Yes** ☐**No**

Verified med list against medication bottle labels?? ☐**Yes** ☐**No**

Comments (including any updates):

Signature/Title /Initials/Date

_____ _____

_____ _____

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