SHARP Grossmont Hospital

Home Medication List

Not a Physician order form **Page ____ of ____**

Patient Name: ____ Date of Birth: ______/_____/ _____

Admission Medication List reviewed with

Patient/Family Name: ____________________________RN :_________________________ Date ________Time_______

List all prescriptions (including insulin, eye drops, inhalers) and non-prescription medications such as Vitamins, aspirin and herbs

Medication Allergies/Intolerances	Describe Reaction
1.	
2.	
3.	
4.	

Current Home Medication	Dose	How Taken	How Often	Last Taken	Comments	Discharge Status** Circle One	Next Dose Due After Discharge
☐ Patient takes no meds			☐ Home med info unavailable				
1.						Consult PCP Continue Stop	
2.						Consult PCP Continue Stop	
3.						Consult PCP Continue Stop	
4.						Consult PCP Continue Stop	
5.						Consult PCP Continue Stop	
6.						Consult PCP Continue Stop	
7.						Consult PCP Continue Stop	
8.						Consult PCP Continue Stop	
9.						Consult PCP Continue Stop	
10.						Consult PCP Continue Stop	
11.						Consult PCP Continue Stop	
12.						Consult PCP Continue Stop	
13.						Consult PCP Continue Stop	

Discharge Medication Reconciliation Addressed

___________________________Date________Time________

Physician Signature

Or (RN signature with name of physician providing instruction)

[ ] No changes to the home medications.

[ ] Following discharge prescriptions have been given pre-operatively:

Additional Medications Prescribed for Home:

Discharge Medication	Dose	How Taken	How Often	Last Taken	Comments	Next Dose Due After Discharge
1.						
2.						
3.						
4.						

RN to Complete

Discharge and Home medications have been reviewed with Patient/Family.

Nurse Signature:________________________________Date________

Patient/Family Signature:________________________Date________

PATIENT IDENTIFICATION