



Medication Reconciliation Physician Order Form

PATIENT LABEL

Room

Information Source: Patient Family: _____ Med List MAR from outside facility Prescription bottles Other: _____
 Translator present; name _____ Outside Pharmacy (name _____ phone # _____)

Allergy Information: No known allergies Iodine Contrast Media Dyes Latex Adhesive tape

Drug/Food/Product	Reaction	Drug/Food/Product	Reaction

Medication Regimen: On no medications at home Unable to obtain Medication history. Reason: _____

Order Now	Do not order at this time	Medication	Dose	Route	Frequency	Last dose Date/time
Routine Scheduled and PRN Medications						
<input type="checkbox"/>	<input type="checkbox"/> Reason: _____ <input type="checkbox"/> Order modified; See separate order					
<input type="checkbox"/>	<input type="checkbox"/> Reason: _____ <input type="checkbox"/> Order modified; See separate order					
<input type="checkbox"/>	<input type="checkbox"/> Reason: _____ <input type="checkbox"/> Order modified; See separate order					
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<input type="checkbox"/>	<input type="checkbox"/> Reason: _____ <input type="checkbox"/> Order modified; See separate order					
<input type="checkbox"/>	<input type="checkbox"/> Reason: _____ <input type="checkbox"/> Order modified; See separate order					

Additional Medications used in the past month						
Comments:						
Comments:						

Herbal Medications (Herbals will <u>not</u> be dispensed by KU Pharmacy)						
Please hold while in hospital						
Please hold while in hospital						

Influenza vaccine (will be dispensed October through February)	Pneumococcal vaccine
Date last given: _____ Do you wish to receive? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Risks/Benefits reviewed <input type="checkbox"/> Please order Influenza 0.5mL IM x 1 (3yrs & older) <input type="checkbox"/> Please order Influenza 0.25 mL IM/SQ x 1 (6-35 months)	Date last given: _____ Do you wish to receive? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Risks/Benefits reviewed <input type="checkbox"/> Please order Pneumovax ® 0.5mL IM/SQ x 1 (2 yrs & older) <input type="checkbox"/> Please order Prevnar® 0.5mL IM/SQ x 1 (under 2 years)

Date: _____ **Person gathering Medication History:** _____ **Pager:** _____
Date/Time: _____ **Ordering Physician:** _____ **Signature** _____ **Pager:** _____

Standardized Medication History Questions

What medications do you take daily that you get from the pharmacy?

Are there any medicines you don't get from the pharmacy that you take everyday?

What medicines do you get from the pharmacy that you only take once in a while?

Are there any other medications that you are not currently taking, but have taken in the last month or so?

What do you take for...

- a. A headache?
- b. Your sinuses/allergies/itchy eyes/runny nose?
- c. An earache?
- d. Dental pain?
- e. A sore throat?
- f. A cough?
- g. Difficulty breathing?
- h. Chest pain?
- i. Your heart?
- j. Upset stomach?
- k. Nausea/vomiting?
- l. Cramps/menses (female only)?
- m. Your urine?
- n. Diarrhea?
- o. Constipation?
- p. General aches and pains?
- q. Changes in skin/rash?

Many people take herbal medicines--are there any that you take?

Is there anything else about your medications that you think I should know?