OUTPATIENT MEDICATION RECONCILIATION FORM

Allergies

Type	Yes	No	List/Describe reaction	Reaction: R = Rash D = Difficulty breathing G= GI upset
Medication				
Food				
Environmental				
Latex Products				
Allergy Band				

List of Patient's Current Medications

☐ **On NO medications at home**

Name of Medication Include prescription, over-the-counter, samples, vitamins, vaccines, herbal products, respiratory treatments, parenteral nutrition, and any other FDA substance listed as a drug		Dose	Frequency	Reason for Taking Required for inpatient admission or if relevant and necessary to care provided in outpatient settings
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				

Patient Signature_____ Date_____ Time_____

Staff Signature_____ Date_____ Time_____

ADVANCED UROLOGY
KINGSTON