Oakland Memorial Hospital
Medication Reconciliation
Rev. 4/06

Name: _____

MR #: _____

Date: _____

*Allergies: _____

Source of Medication List: (check all used)

____ Patient medication list
____ Patient/Family Recall
____ Pharmacy
____ Primary Care physician list
____ Previous discharge paperwork
____ Medication Administration Record from facility
____ Other

Physician's Signature/Initials

_____
_____
_____

Med. History Recorded/Verified by: _____

Medication Reconcilliation:

Admission _____
Transfer _____
Dismissal _____

Date Time Initials	Doctor Orders Hospital Admit	Nurse Date Initials	Medication Name	Dose	Route	Frequency	Time Last Dose Taken	Physician Orders					
								In-house Transfer	Doctor Date Initials	Nurse Date Initials	Hospital Discharge	Doctor Date Initials	Nurse Date Initials
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