

SAMPLE: Medication Reconciliation Record and Order Form

[Date Created]

[Completed Medication Reconciliation Record and Order Form |Partially Completed Medication Reconciliation Record and Order Form]

Dr. A Blog [License No.]
 1-100 Smith Street
 Winnipeg, MB R2V3P3
 (204) 287 237-2863

Client Surname:
 Given Name:
 Date of Birth: Gender:
 MFRN:
 PHIN:
 Address:

List of Allergies / Intolerances and Reactions: [_____]

Weight (kgs) and date last recorded: [_____]

Medications Verified with: Patient Caregiver Unable to Perform Reason: _____

INFORMATION SOURCE: Bubble pack Home medication list Medication vials
 Community pharmacy Medication Administration Record Other: _____

Best Possible Medication History - includes prescription, non-prescription, traditional, holistic, herbal, vitamins and supplements	
Active Prescriptions (include Continuous, Short Term, External, Administered Medications) NOTE: Don't identify these categories just list all medications within these categories)	List any comments or reasons for continuing:
1) New Rx (Substitutions allowed) #ACC1261996 AMLODIPINE 5 MG TABLET 1 Tablet(s) once Daily x 90 Day(s) Starting on 2016-Feb-01 ending on 2017-February 01 SIG Instructions: 1 tablet daily Qty: 90 Tablet(s) (Ninety) Refills: 3 (Three) Drug use: Continuous Route: Oral DIN: 02429217	<input type="checkbox"/> Medication Reconciliation Complete <input type="checkbox"/> Medication Reconciliation In Progress <input type="checkbox"/> Requires a Referral <input type="checkbox"/> Other [_____]
2) New Rx (Substitutions allowed) #ACC1261996 CARDIZEM 120 MG TABLET 1 Tablet(s) twice Daily x 90 Day(s) Starting on 2016-Feb-01 ending on 2017-February 01 SIG Instructions: 1 tablet daily Qty: 90 Tablet(s) (Ninety) Refills: 3 (Three) Drug use: Continuous Route: Oral DIN: 02429217	<input type="checkbox"/> Medication Reconciliation Complete <input type="checkbox"/> Medication Reconciliation In Progress <input type="checkbox"/> Requires a Referral <input type="checkbox"/> Other [_____]
Managed by Another Prescriber	List any comments:
3) New Rx (Substitutions allowed) #ACC1261996 AMLODIPINE 5 MG TABLET 1 Tablet(s) once Daily x 90 Day(s) Started on 2016-Feb-01 SIG Instructions: 1 tablet daily Qty: 0 Tablet(s) (Zero) Refills: 0 (Zero)	<input type="checkbox"/> Medication Reconciliation Complete <input type="checkbox"/> Medication Reconciliation In Progress [has been referred to Dr Flog] <input type="checkbox"/> Requires a Referral [Dr. Blatz] <input type="checkbox"/> Other [_____]

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Drug use: Continuous Route: Oral DIN: 02429217	
Changed (includes ONLY Recently Active Medications that have been changed)	List any comments or reasons for prescription change:
New Rx (Substitutions allowed) #ACC1261996 CARDIZEM 180 MG TABLET 1 Tablet(s) twice Daily x 90 Day(s) starting on 2016-Feb-01 SIG Instructions: 1 tablet daily Qty: 0 Tablet(s) (Zero) Refills: 0 (Zero) Drug use: Continuous Route: Oral DIN: 02429217	<input type="checkbox"/> Change in medication or dose <input type="checkbox"/> Intolerance <input type="checkbox"/> Disease <input type="checkbox"/> Other [_____]
Discontinued (includes ONLY Recently Active Medications that were discontinued)	List any comments or reasons for discontinuing:
New Rx (Substitutions allowed) #ACC1261996 LASIX 10 MG TABLET 1 Tablet(s) once Daily x 90 Day(s) starting on 2016-Feb-07 SIG Instructions: 1 tablet daily Qty: 0 Tablet(s) (Zero) Refills: 0 (Zero) Drug use: Continuous Route: Oral DIN: 02429217	<input type="checkbox"/> Allergy <input type="checkbox"/> Intolerance <input type="checkbox"/> Compliance issues <input type="checkbox"/> Rx longer required <input type="checkbox"/> Drug interacts with another drug <input type="checkbox"/> Drug product discontinued or recalled <input type="checkbox"/> Duplicate Therapy <input type="checkbox"/> Disease <input type="checkbox"/> Other [_____]

Populate what the user has selected with any details

Medication History Taken by	Date	Time	Medication Reconciliation completed by:	Date	Time
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Populate both of these with logon, credentials and date/time stamped

For Faxed Prescription Only:

1. This prescription represents the original of the prescription drug order.
2. The Pharmacy addressee noted above is the only intended recipient and there are no others.
3. The original prescription has been invalidated and securely filed and it will not be transmitted elsewhere at another time.
4. Quantity must be stated in words and numbers.

CONFIDENTIALITY WARNING:

This document contains confidential information intended for a specific individual and purpose. The information is private and is legally protected by law. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or the taking of any action in reference to the contents of this telecopied information is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone [autopopulate office phone number] and return the original by regular mail.

Generated By Dr. A Blog [Credentials (MD)] on [Date and Time stamp]

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Client Surname:
Given Name:
Date of Birth: Gender:
MFRN:
PHIN:
Address:

Signature _____
Designation

*** Please take this prescription to your pharmacist***



Allow for the forms editor for all Prescribers to add their Electronic signature

SAMPLE