NORTHSIDE HOSPITAL

Georgia Colon & Rectal Surgical Associates

Patient Name _____

Date of Birth _____ /_____ /_____
Month Day Year

MEDICATION RECONCILIATION FORM

☐ No Medications prescribed by other physicians

Pharmacy_____ Pharmacy Phone # _____

Date Entry Made	Additional Medications Taken by Patient (Prescriptions, OTC, Herbals, Patches, Inhalers, Eye Drops, Topicals & Supplements)							
	Drug Name and Dose	**Route**	**Frequency**	**Indication if PRN**	**Start date**	**Staff Initials**	**Discontinue date**	**Staff Initials**

Date Entry Made	Medication / Food / Environmental Allergies	Reaction / Comments	Staff Initials

Visit Date	Review	Staff Initials	MD Initials	Visit Date	Review	Staff Initials	MD Initials
	☐ Reviewed, no change ☐ Reviewed, see change above				☐ Reviewed, no change ☐ Reviewed, see change above		
	☐ Reviewed, no change ☐ Reviewed, see change above				☐ Reviewed, no change ☐ Reviewed, see change above		
	☐ Reviewed, no change ☐ Reviewed, see change above				☐ Reviewed, no change ☐ Reviewed, see change above		
	☐ Reviewed, no change ☐ Reviewed, see change above				☐ Reviewed, no change ☐ Reviewed, see change above		
	☐ Reviewed, no change ☐ Reviewed, see change above				☐ Reviewed, no change ☐ Reviewed, see change above		

Reorder #34621 PP0410 (GCR)
Piedmont Graphics Rev. 10/27/17

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