Pharmacy: ________________________ Phone: ____________________ Fax: _________________________

Allergies/Adverse Reactions/Sensitivities

Date	Time	Name of Allergies (Medication, Food, etc.)	Type of Reaction (Describe -e.g. itching etc.)	Initials

DIRECTIONS: Enter date discontinued when applicable and rewrite new or changed medications on a new line. Provide initial copy to patient upon admission, with any changes and/or when patient is admitted to another organization that requires ongoing care. Upon discharge, provide copy to the patient along with education on the importance of sharing medication information with other care provider(s).

List all Over-the-counter medication (Includes vitamins/minerals, herbal/natural products and recreational)

Date	Time	Medication	Dose	Frequency	Route	Propose	Initials	Date Discontinued	Initials

List all medications that patient reported as prescribed for them

Date	Time	Medication	Dose	Frequency	Route	Propose	Initials	Date Discontinued	Initials

List all medications prescribed by Wound Care Center Physicians

Date	Time	Medication	Dose	Frequency	Route	Propose	Initials	Date Discontinued	Initials

_______________________________ / __________ _______________________________ / __________
Nurse Signature Initials Nurse Signature Initials

_______________________________ / __________ _______________________________ / __________
Nurse Signature Initials Nurse Signature Initials

MEDICATION RECONCILIATION

DOC NO WC00016 06/29/16) AR

Do Not Place Below This Line.

DIRECTIONS: Enter date discontinued when applicable and rewrite new or changed medications on a new line. Provide initial copy to patient upon admission, with any changes and/or when patient is admitted to another organization that requires ongoing care. Upon discharge, provided copy to the patient along with education on the importance of sharing medication information with other care provider(s).

List all Over-the-counter medication (Includes vitamins/minerals, herbal/natural products and recreational)

Date	Time	Medication	Dose	Frequency	Route	Propose	Initials	Date Discontinued	Initials

List all medications that patient reported as prescribed for them

Date	Time	Medication	Dose	Frequency	Route	Propose	Initials	Date Discontinued	Initials

List all medications prescribed by Wound Care Center Physicians

Date	Time	Medication	Dose	Frequency	Route	Propose	Initials	Date Discontinued	Initials

_______________________________ / __________ _______________________________ / __________

Nurse Signature Initials Nurse Signature Initials

_______________________________ / __________ _______________________________ / __________

Nurse Signature Initials Nurse Signature Initials

MEDICATION RECONCILIATION

DOC NO WC00016 (06/29/16) AR

PATIENT LABEL

Do Not Place Below This Line.