Milford Regional
Medical Center

OUTPATIENT SERVICES
MEDICATION RECONCILIATION FORM

Date and Time:_____/_____

Allergy/Intolerance	Reaction(s)	Allergy/Intolerance	Reactions(s)	Allergy/Intolerance	Reaction(s)
1.		3.		5.	
2.		4.		6.	

Patient's Pharmacy:_____ Pharmacy address:_____

Medications(s) Prior to Admission

List all medications, nutritionals, herbal supplements and pumps or patches used prior to this visit or admission.
Source: ☐ Patient ☐ Family ☐ Provided List ☐ Other_____
Obtained by:_____

Medication (Include Strength)	Directions (Dose, Route, Freq)	Indication (Reason)	Last Dose (Date/Time)	Resume Meds on Discharge	Resume Date/Time
1.				YES NO	
2.				YES NO	
3.				YES NO	
4.				YES NO	
5.				YES NO	
6.				YES NO	
7.				YES NO	
8.				YES NO	
9.				YES NO	
10.				YES NO	
11.				YES NO	
12.				YES NO	
13.				YES NO	
14.				YES NO	
15.				YES NO	

******Please bring this medication record with you to your physician office or on return to the hospital******

Based on your visit to Milford Regional Medical Center, you may safely continue only the medications circled YES in the RESUME Meds on Discharge column above. If you have any questions, please contact your primary physician or surgeon.

Prescriptions Given at Discharge

Medication (include strength)	Dose/Route/Frequency	Indication	Next Dose
1.			
2.			
3.			
4.			

*****Check MassPAT for all NEW controlled Rx's *****

MD Signature:_____ **Date:**_____ **Time:**_____

RN at Discharge Signature:_____ **Date:**_____ **Time:**_____

Prohibited Abbreciations: u, qd, qod, MS, MS04, MgSO4, ug, .1 (use0.1), 1.0 (use 1), SPA, CTX, IU
USE BALL POINT PEN ONLY