PAIN & PALLIATIVE CARE SERVICES
an Affiliate of Monocacy Health Partners

MEDICATION RECONCILIATION

PATIENT NAME: _____

DOB: _____ **MR#** _____

ALLERGIES:			**Review every medication at every visit by indicating if the patient currently takes (C) or has discontinued taking (DC) and initial**						
MEDICATION	**DOSE**	**HOW OFTEN**	**Date, Time/ Initials**	**Date, Time/ Initials**	**Date, Time/ Initials**	**Date, Time/ Initials**	**Date, Time/ Initials**	**Date, Time/ Initials**	**Date, Time/ Initials**

Initials / Name

_____ / _____

_____ / _____

_____ / _____

11/2013