JASC MEDICATION RECONCILIATION FORM
Pain Management Medication Reconciliation List

Patient Name: **Allergies:**

Please include all prescription, over-the-counter, vitamins and herbal / natural medications taken routinely prior to admission.

Data Source: ☐ Patient ☐ Family ☐ Other: ____________ **Patient's Pharmacy & Phone #:** ____________

Medication	Dosage	Frequency (When)	Indication (Why Taking Meds)	**To Be Completed by Nurse** Date: Date Medication Last Taken	Date: Date Medication Last Taken	Date: Date Medication Last Taken	Date: Date Medication Last Taken
1)							
2)							
3)							
4)							
5)							
6)							
7)							
8)							
9)							
10)							
11)							
12)							
13)							
14)							
15)							
16)							

Attention: Please continue to page 2, if you have additional medications to list.

Patient Signature *Please provide signature once per visit. **Date** — **Nurse Signature** **Date**

Patient Signature *Please provide signature once per visit. **Date** — **Nurse Signature** **Date**

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				DATE:	DATE:	DATE:	DATE:
				Date Medication Last Taken	Date Medication Last Taken	Date Medication Last Taken	Date Medication Last Taken
17)							
18)							
19)							
20)							
21)							
22)							
23)							
24)							
25)							
26)							
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35)							