

**JASC MEDICATION RECONCILIATION FORM**  
**Pain Management Medication Reconciliation List**

Patient Name \_\_\_\_\_

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

Allergies \_\_\_\_\_

Data Source:  Patient  Family  Other: \_\_\_\_\_

Patient's Pharmacy & Phone#: \_\_\_\_\_

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

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

\_\_\_\_\_  
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
13)							
14)							
15)							
16)							
17)							
18)							
19)							
20)							
21)							
21)							
22)							
23)							
24)							
25)							

Patient Sticker Visit 1

Patient Sticker Visit 2

Patient Sticker Visit 3

Patient Sticker Visit 4