

**McLaren Print System Order**

Order No: 59936  
 Order Date: 2021-01-29  
 User: chad chunko  
 Phone: 8103422235

Ship Location: Medical education building, lower level  
 G3230 beecher road  
 flint, mi 48532

**Forms**

Quantity: 500  
 Paragon Dept No: 40110  
 Dept Name: Pulmonary Rehab  
 Company Number: 60

Order Total Price: 0.00

Item Number: 17762  
 Item Description: Medication Reconciliation Report  
 Revision Date: 9/2012  
 Print: 1 sided black and white  
 Paper: 20# White Text  
 Size: 8.5 x 11  
 Fold:  
 Finish: None  
 Drill: None  
 Misc Info:

McLaren-PRB  
 Outpatient Pulmonary Rehabilitation Program  
**MEDICATION RECONCILIATION REPORT**

Entry Assessment by: \_\_\_\_\_ NPT Date: \_\_\_\_\_

Drug Allergies		Food Allergies		Other Allergies	
<input type="checkbox"/> NO-known drug allergies		<input type="checkbox"/> NO-known food allergies		<input type="checkbox"/> NO (Other known allergies)	
1. _____	1. _____	1. LATE: <input type="checkbox"/> YES <input type="checkbox"/> NO			
2. _____	2. _____	2. _____			
3. _____	3. _____	3. _____			
Reaction: _____	Reaction: _____	Reaction: _____			

Name of Medicine	Initial Dose	Initial Frequency	Completed to:	Change Date	Continue if Discharge
<b>Pulmonary Medications</b>					
1. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
2. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
3. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
4. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
5. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
6. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>Cardiovascular Medications</b>					
<input type="checkbox"/> Write across					
1. Anti-arrhythmic			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
2. ACE / ARB			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Beta-blocker			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
4. Diuretic			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
5. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
6. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>Other Physician Prescribed Medications</b>					
1. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
2. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
3. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
4. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
5. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
6. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
7. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
8. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
9. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
10. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>Self-Administered: OTC, vitamins, Minerals, Herbs</b>					
1. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
2. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO

Exit Assessment by: \_\_\_\_\_ NPT Date: \_\_\_\_\_

copied to:  Patient  Physician  Other \_\_\_\_\_

Spec Info:

