McLaren Flint

Flint, Michigan

AMBULATORY MEDICATION RECONCILIATION FORM

ALLERGIES:			Date/Initials Date/Initials					
								PHARMAC
CURREN	T HOME MEDICATI	ONS (PRESCRIPTION	NS, OTC, HERBALS, PA	TCHES, INHALERS	, EYE DROPS, SUF	PPLEMENTS, RESEA	ARCH MEDS, ETC.)	
	Drug Name* (include dose, route, fr	equency)	Date Reviewed / Initials					
. <u> </u>								
*Any new me	edication orders (new sta	ırts or regimen chanç	ges) should be ente	red on a new lin	e.			
KEY:								
	Name:							
							Clinic:	
Initials:	Name:	Clinic:	inic: Initials: Name: Clinic:					

Page ____ of ____ AMBULATORY MEDICATION **RECONCILIATION FORM**



PT.

MR.#/P.M.