



## Best Possible Medication History (BPMH) and Admission Reconciliation & Order Form

Allergies/Intolerances (& reactions):

No Known Allergies    Unable to Obtain

Unable to Obtain Medication History - Reason:

Medications Taken Prior to Admission (Prescription, Non-prescription, Alternative) <b>Medication, Dose, Route, Frequency</b>	Information Source(s): <input type="checkbox"/> DPIN <input type="checkbox"/> Community Pharmacy <input type="checkbox"/> Patient/Caregiver <input type="checkbox"/> Other _____	Last Dose Taken	<b>Prescriber Review &amp; Order</b> Review each medication & check off appropriate box			
			Con- tinue	Do Not Order	Change (see last column)	Change to Medication Taken Prior to Admission and Reason
<input type="checkbox"/> Takes No Medications			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**Use a second form if there is insufficient space & indicate the page number in the bottom right hand corner**

**See Physician/Prescriber Order sheet for new medication, lab or diet orders.**

**Compliance and Assessment of Educational Needs**

**DVT/VTE Prophylaxis (See back of orders for Risk Stratification)**

Heparin 5000 Units SubCut BID       No Prophylaxis Required

Dalteparin 5000 Units SubCut Daily       Already Adequately Prophylaxed

Mechanical Prophylaxis -  
    Antiembolic Stockings (AES)      Rationale: \_\_\_\_\_

Review with patient "Clot Prevention" teaching sheet

How often do you miss doses:    Seldom    more than 2/wk

Why do you forget? \_\_\_\_\_

Have you stopped, started or changed any drugs in the past 3 months    Yes    No \_\_\_\_\_

Who administers your medications? \_\_\_\_\_

Do you keep a Medication List?    Yes    No

Is the list up to date?                       Yes    No

**Prescriber Signature:** \_\_\_\_\_      **Date:** \_\_\_\_\_      **Time:** \_\_\_\_\_

**Med History Taken By:** \_\_\_\_\_      **Date:** \_\_\_\_\_      **Time:** \_\_\_\_\_

**Orders Transcribed By:** \_\_\_\_\_      **Date:** \_\_\_\_\_      **Time:** \_\_\_\_\_

**Orders Faxed/Scanned to Pharmacy**      **Date:** \_\_\_\_\_      **Time:** \_\_\_\_\_      **Unit:** \_\_\_\_\_      **Page** \_\_\_\_\_ **of** \_\_\_\_\_