Facility Name

Medication Reconciliation and Discharge Order Form

Facility Address

Name: **Example, Name** **Sex:** F **Location:** **Facility UNIT ROOM**
MRN : **111111** **Birth Date:** DD-MM-YYYY
PHIN : **1111111111** **Age :** YY yrs **Home Phone :** **123 5678844**
Physician: Name, Dr. **Address :** Address
Allergies: No Known Allergies City, MB
POSTAL CODE

Continue	Change (see new order)	Dis-continue	Medication, Dose, Route, and Frequency	Qty and # of Refills	Comments
			atorvastatin Tab 10 mg Directions: 10 mg = 1 Tab By Mouth Daily With Supper (LIPITOR)		
			clonazePAM Tab 0.5 mg Directions: 0.75 mg = 1.5 Tab By Mouth At Bedtime (RIVOTRIL) for 2 weeks then decrease Start: Mar 03, 2022 Stop: Mar 16, 2022		
			clonazePAM Tab 0.5 mg Directions: 0.5 mg = 1 Tab By Mouth At Bedtime (RIVOTRIL)		
			clotrimazole Cream 1% (25 g) Directions: Topically to groin Twice Daily For 14 Days Then Reassess Start: Mar 06, 2022 Stop: Mar 20, 2022		
			dalteparin Syringe 5,000 units/0.2 mL Directions: 5000 unit(s) = 0.2 mL SubCutaneous Daily (FRAGMIN)		
			diphenhydrAMINE Cap 25 mg Directions: 50 mg = 2 Cap By Mouth At Bedtime (BENADRYL) for 6 doses then re-assess Mar 12th Start: Mar 06, 2022 Stop: Mar 11, 2022		
			loperamide Tab 2 mg Directions: 2 mg = 1 Tab By Mouth Every Morning MAX: 16 MG=8 TABS/24 HRS (IMODIUM)		

Physician Print Name : _____

Physician Signature : _____

Date/Time : _____ License # : _____

Scheduled meds to be provided in bubblepacks? **YES** **NO**

Primary Care Physician : _____

Practitioner Certification

- This prescription represents the original of the prescription drug order.
- The pharmacy addressee noted above is the only intended recipient and there are no others.
- The original prescription has been invalidated and securely filed, and it will not be transmitted elsewhere at another time.

Confidential Facsimile to :

Pharmacy Name : _____

Pharmacy Fax # : _____

Phone Number : _____

☐ Faxed Initials : _____

Date : _____ Time : _____

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Continue	Change (see new order)	Dis-continue	Medication, Dose, Route, and Frequency	Qty and # of Refills	Comments
			magnesium gluconate Tab 500 mg Directions: 500 mg = 1 Tab By Mouth Twice Daily		
			PARoxetine Tab 20 mg Directions: 20 mg = 1 Tab By Mouth Daily (PAXIL)		
			ramipril Cap 5 mg Directions: 5 mg = 1 Cap By Mouth Daily		
			tiotropium Inh 2.5 mcg/Puff Directions: 2 Puff via Inhalation Daily *SPIRIVA RESPIMAT*		
			traZODone Tab 50 mg Directions: 25 mg = 0.5 Tab By Mouth At Bedtime		
			vitamin B12 (cyanocobalamin) Tab 1,000 mcg Directions: 1000 mcg = 1 Tab By Mouth Daily		

Physician Print Name : _____

Physician Signature : _____

Date/Time : _____ License # : _____

Scheduled meds to be provided in bubblepacks? **YES** **NO**

Primary Care Physician : _____

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Physician: Name, Dr. **Address :** Address
Allergies: No Known Allergies City, MB
POSTAL CODE

Continue	Change (see new order)	Dis-continue	PRN Medications, Dose, Route, and Frequency	Qty and # of Refills	Comments
			acetaminophen cpd/codeine Tab 30 mg Directions: 1 to 2 Tab By Mouth Every 4 To 6 Hours As Needed (TYLENOL No. 3 EQUIV)		
			acetaminophen Tab 325 mg Directions: 650 mg = 2 Tab By Mouth Every 4 Hours As Needed (TYLENOL) Maximum 4 g in 24 hours		
			antacid Susp . Directions: 15 to 30 mL By Mouth Three Times Daily As Needed		
			clobetasol Cream 0.05% (15 g) Directions: Topically Twice Daily As Needed for Itch For 7 days (DERMOVATE) DO NOT APPLY TO FACE OR INTERTRIGINOUS AREAS Start: Mar 07, 2022 Stop: Mar 14, 2022		
			loperamide Tab 2 mg Directions: 2 mg = 1 Tab By Mouth Four Times Daily As Needed MAX: 16 MG=8 TABS/24 HRS (IMODIUM)		
			ondansetron Tab 4 mg Directions: 4 mg = 1 Tab By Mouth Three Times Daily As Needed (ZOFRAN)		

Physician Print Name : _____

Physician Signature : _____

Date/Time : _____ License # : _____

Scheduled meds to be provided in bubblepacks? **YES** **NO**

Primary Care Physician : _____

Practitioner Certification

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Restart	Discontinue	Pre-admission medications not ordered in hospital (medication, dose, route, and frequency)	Qty and # of Refills	Comments

New and changed medications at time of discharge (medication, dose, route, and frequency)	Qty and # of Refills	Comments

Physician Print Name : _____

Physician Signature : _____

Date/Time : _____ License # : _____

Scheduled meds to be provided in bubblepacks? **YES** **NO**

Primary Care Physician : _____

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