## **Medication Reconciliation and Discharge Order Form**

**Facility Address** 

Name: Example, Name

Sex: F

Location: Facility UNIT ROOM

MRN: 111111 Birth Date: DD-MM-YYYY

Physician:Name, Dr.Address:AddressAllergies:No Known AllergiesCity, MBPOSTAL 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	ĺ	
			Directions: 2 mg = 1 Tab By Mouth Every Morning MAX: 16 MG=8 TABS/24 HRS (IMODIUM)		

Physician Print Name :		Confidential Facsimile to :
Physician Signature :		Pharmacy Name :
Date/Time :	License # :	Pharmacy Fax # :
Scheduled meds to be provided in bubble	epacks? YES NO	Phone Number :
Primary Care Physician :		Faxed Initials :
Practitioner Certification		Date : Time :

- 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.

THIS TELECOPY IS **CONFIDENTIAL** AND IS INTENDED TO BE RECEIVED BY THE ADDRESSEE ONLY. IF THE READER IS NOT THE INTENDED RECIPIENT THEREOF, YOU ARE ADVISED THAT ANY DISSEMINATION, DISTRIBUTION OR COPYING OF THIS FACSIMILES IS **STRICTLY PROHIBITED.** 

Printed On: 09-Mar-2022 09:16 report/profiles/patient\_discharge\_orderform\_mb Job ID# = 19706162 Page 1 of 4

## **Medication Reconciliation and Discharge Order Form**

**Facility Address** 

Name: Example, Name Sex: F **Location: Facility UNIT ROOM** 

MRN: 111111 Birth Date: DD-MM-YYYY

Age: YY yrs Home Phone: 123 5678844 PHIN: 11111111111

Address: Address Physician: Name, Dr. 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
			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 :		Confidential Facsimile to :
Physician Signature :		Pharmacy Name :
Date/Time :	License # :	Pharmacy Fax # :
Scheduled meds to be provided in bubble	packs? YES NO	Phone Number :
Primary Care Physician :		Faxed Initials :
Practitioner Certification		Date : Time :

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Printed On: 09-Mar-2022 09:16 report/profiles/patient\_discharge\_orderform\_mb Job ID# = 19706162 Page 2 of 4

August 31, 2023

## **Medication Reconciliation and Discharge Order Form**

**Facility Address** 

Name: Example, Name

MRN: 111111

PHIN: 1111111111 Physician: Name, Dr. Allergies: No Known Allergies

Sex: F Birth Date: DD-MM-YYYY

Age: YY yrs

**Location: Facility UNIT ROOM** 

Home Phone: 123 5678844

Address: Address

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 :		Confidential Facsimile to :
Physician Signature :		Pharmacy Name :
Date/Time : License # :		Pharmacy Fax # :
Scheduled meds to be provided in bubblepacks? YE	S NO	Phone Number :
Primary Care Physician :		Faxed Initials :
Practitioner Certification		Date : Time :

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# **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: 11111111111

Age: YY yrs

Physician: Name, Dr.

Address: Address City, MB

Allergies: No Known Allergies

POSTAL CODE

Home Phone: 123 5678844

Restart	Discontinue	Pre-admission medications not order (medication, dose, route, and free		Qty and # of Refills	Comments	
		d changed medications at time of dischar edication, dose, route, and frequency)	ge	Qty and # of Refills	Comments	
Physician	Print Name :		Confidentia	I Facsimile to :		
Physician	Signature :					
Date/Time	:	License # :				
Scheduled meds to be provided in bubblepacks? YES NO			Phone Num	ber :		
Primary Care Physician :			Faxed	Faxed Initials :		

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**Practitioner Certification** 

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