Gwinnett Hospital System

PLACE LABEL HERE

HOME MEDICINE LIST – OUTPATIENT SERIES/CLINIC

(MEDICATION RECONCILIATION)

ALLERGIES (Medicine, food, iodine) and describe reaction	❑ **No Known Allergies**

Date/ Initials	Medicine Name Include prescriptions, over the counter medicines, herbals, vitamins	Dose How many mg, mcg?	How Often? Once a day, before meals	Comments or Changes Patient's Pharmacy Phone #___________
	❑ Patient takes no home medicines		❑ Every day ❑ __times a day ❑ As needed ❑ Other______	
			❑ Every day ❑ __times a day ❑ As needed ❑ Other______	
			❑ Every day ❑ __times a day ❑ As needed ❑ Other______	
			❑ Every day ❑ __times a day ❑ As needed ❑ Other______	
			❑ Every day ❑ __times a day ❑ As needed ❑ Other______	
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			❑ Every day ❑ __times a day ❑ As needed ❑ Other______	
			❑ Every day ❑ __times a day ❑ As needed ❑ Other______	

GHS Associate Use at Each Visit:

Date/ Initials	Time	Signature of GHS Associate Reviewing Home Medicines	Date/ Initials	Time	Signature of GHS Associate Reviewing Home Medicines

If this visit resulted in a medication change, fax form to the next provider(s) and give a copy to the patient.

Date	Next Provider	Fax Number	Date	Next Provider	Fax Number