

BMC NBH SBH NCBH SLBH BHS

OUTPATIENT HOME MEDICATION LIST

PATIENT NAME: _____
 AGE: _____ DOB: _____ SEX: _____
PATIENT LABEL
 MEDICAL RECORD # _____
 ACCOUNT # _____

Height (in) _____ Weight (lbs) _____ kg	Allergies / Intolerance(s) _____ _____ _____	Reaction(s) _____ _____ _____
Diabetes <input type="checkbox"/> Y <input type="checkbox"/> N Dialysis <input type="checkbox"/> Y <input type="checkbox"/> N		
FEMALES ONLY Pregnant <input type="checkbox"/> Y <input type="checkbox"/> N Breastfeeding <input type="checkbox"/> Y <input type="checkbox"/> N		

Source: As stated by patient / family Outpatient pharmacy Physician office list H & P Nursing home / Home health
Disposition of medications: Sent home with patient/family (name) _____

DIRECTIONS: List all prescription and non-prescription medications used prior to this visit, including: aspirin, insulin, eye drops, inhalers, nutritional and herbal supplements and all pumps or patches. If more than one form is required to document all medications, indicate the number of forms in the space listed on line 15.

DO NOT USE ABBREVIATIONS:

lv qd MS u
 MgSO4 qod MS04
 With a zero always lead and never follow a decimal point.
 For example use (Xmg) not (X.0mg), (0.Xmg) not (Xmg).

	Drug Name	Dose (strength)	Route	Frequency	Indication	Initials	DC Date	New Date
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

15. _____ Number of forms required to document all medications. This is page _____.

Not taking any home medication(s)

Form initiated by: (Signature / Title) _____

Emp# _____ Date: _____ Time: _____

Initials	Signature/Title	Emp#	Initials	Signature/Title	Emp#



DC= Discontinued Line through all discontinued medications

Xerox copy provided to patient on initial visit and with all changes.