LIGS
LONG
ISLAND
GASTROENTEROLOGY
SPECIALISTS

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MEDICATION RECONCILIATION FORM

Patient Name:________________________________

DOB: _________________ ID#: _______________

KEY POINTS: **Do NOT** use any **UNSAFE** abbreviations: QD, IU, U, O (trailing zeros after decimal), QOD

ALLERGIES:____

MEDICATION NAME	DOSE	ROUTE	FREQUENCY	DATE/TIME OF LAST DOSE	CONTINUE MEDICATION	
					YES	NO
					YES	NO
					YES	NO
					YES	NO
					YES	NO
					YES	NO
					YES	NO
					YES	NO
					YES	NO
					YES	NO
					YES	NO
					YES	NO
					YES	NO
					YES	NO
					YES	NO
					YES	NO
					YES	NO
					YES	NO
					YES	NO
					YES	NO
					YES	NO
					YES	NO

SPECIAL INSTRUCTIONS:

RN Signature for medication reconciliation process:

MD SIGNATURE: