Date/Time:_____/_____ Height (in):_____ Weight (lb):_____ Smoking? Y/N

Pregnant? ☐ Yes (_____ weeks gestation) ☐ No Breastfeeding? Y/N

ALLERGY/INTOLERANCE	REACTION(S)	ALLERGY/INTOLERANCE	REACTION(S)	ALLERGY/INTOLERANCE	REACTION(S)
1		4		7	
2		5		8	
3		6		9	

MEDICATION(S) PRIOR TO ADMISSION

[List all **medications, nutritionals, herbal supplements,** and **pumps** or **patches** used prior to this visit or admission.]

Source: ☐ Patient ☐ Family ☐ Provided List ☐ Other_____

MEDICATION (include strength)	DIRECTIONS (Dose, Route, Freq)	INDICATION (Reason)	LAST DOSE (Date/Time)	RESUME MEDS? ADMIT YES NO	RESUME MEDS? DISCH YES NO
				Y N	Y N
				Y N	Y N
				Y N	Y N
				Y N	Y N
				Y N	Y N
				Y N	Y N
				Y N	Y N
				Y N	Y N
				Y N	Y N
				Y N	Y N
				Y N	Y N
				Y N	Y N
				Y N	Y N
				Y N	Y N
				Y N	Y N

Based on your visit at Lakeside Women's Hospital you may safely continue **only** the medications circled '**DISCH Yes**' above. If you have any questions, please contact your primary physician.

Signature of RN/LPN at Admission_____

PRESCRIPTIONS GIVEN AT DISCHARGE

MEDICATION (include strength)	DOSE – ROUTE – FREQUENCY	INDICATION	NEXT DOSE

****Please bring this medication record with you to your physician's office or return to the hospital****

Page ____ of ____

Signature of RN/LPN at Discharge_____

Lakeside Women's Hospital

MEDICATION RECONCILIATION

(PLACE PATIENT'S LABEL HERE)

WHITE - Medical Record Copy **YELLOW** - Physician Copy **PINK** - Patient Copy