

**HOME MEDICINE LIST – OUTPATIENT SERIES**  
(MEDICATION RECONCILIATION)

NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

<b>ALLERGIES</b> (Medicine, food, iodine) and describe reaction	<input type="checkbox"/> <b>No Known Allergies</b>

<u>Date/ Initials</u>	<u>Medicine Name</u> <small>Print Clearly Include prescriptions, over the counter medicines, herbals, vitamins</small>	<u>Dose</u> <small>How many mg, mcg?</small>	<u>How Often?</u> <small>Once a day, before meals</small>	<u>Comments or Changes</u>
	<input type="checkbox"/> Patient takes no home medicines		<input type="checkbox"/> Every day <input type="checkbox"/> ___ times a day <input type="checkbox"/> As needed <input type="checkbox"/> Other _____	
			<input type="checkbox"/> Every day <input type="checkbox"/> ___ times a day <input type="checkbox"/> As needed <input type="checkbox"/> Other _____	
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**GMG Associate Use at Each Visit:**

Date/ Initials	Time	Signature of GMG Associate Reviewing Home Medicines

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

Date	Next Provider	Fax Number

Date	Next Provider	Fax Number

