GWINNETT MEDICAL GROUP

PLACE LABEL HERE

HOME MEDICINE LIST – OUTPATIENT SERIES
(MEDICATION RECONCILIATION)

NAME: ______________________________________ DATE OF BIRTH: __________________________

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

Date/ Initials	**Medicine Name** Print Clearly Include prescriptions, over the counter medicines, herbals, vitamins	**Dose** How many mg, mcg?	**How Often?** Once a day, before meals	**Comments or Changes**
	☐ 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_______	
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			☐ Every day ☐ ___times a day ☐ As needed ☐ Other_______	
			☐ Every day ☐ ___times a day ☐ As needed ☐ Other_______	

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

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