Anticoagulation Clinic Medication Reconciliation Document

Patient Information

Name:

Date of Birth:

Medical Record Number:

Visit Date:

Anticoagulant Medication(s)

Medication Name	Strength	Dosage	Route	Frequency	Last Dose Date/Time	Notes

Other Current Medications

Medication Name	Strength	Dosage	Route	Frequency	Notes

Allergies

Drug/Food/Other Allergies:

Reconciliation Review Notes

Notes:

Reviewed By

Clinician Name:

Date: