Geriatric Medication Reconciliation Checklist

Patient Information

Name:

DOB:

Medical Record #:

Date:

Current Medication List

Medication Name	Dosage	Route	Frequency	Indication	Prescriber

Supplements/OTC/Herbals

Product	Dosage	Frequency	Indication

Allergies / Adverse Reactions

Substance	Reaction

Medication Changes

Medication	Change (Start/Stop/Modify)	Reason

Potential Issues

Reconciled By

Name:

Role:

Date: