

# Hospital Admission Medication Reconciliation Form

## Patient Information

Patient Name

Date of Birth

Medical Record Number

Admission Date

Attending Physician

## Medication History

| Medication Name | Dosage | Route | Frequency | Last Dose Taken | Comments |
|-----------------|--------|-------|-----------|-----------------|----------|
|                 |        |       |           |                 |          |
|                 |        |       |           |                 |          |

## Source(s) of Medication History

## Medication Allergies

## Comments / Additional Information

## Reconciliation Performed By

Name

Date

Signature