

Telemedicine Medication Reconciliation Form

Patient Name

Date of Birth

Medical Record Number

Telemedicine Appointment Date

Provider Name

Current Medications

Medication Name	Dosage	Route	Frequency	Indication	Prescriber
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Allergies

Drug Allergies

Other Allergies

Medication Changes

Additions

Discontinuations

Dosage/Instruction Changes

Notes