

**San Antonio Community Hospital  
Ambulatory Services  
Medication Reconciliation Record**

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List all medications that you are currently taking at home including those prescribed by a physician and over-the-counter drugs such as vitamins, Aspirin, Tylenol and herbals.

**Does not take any medications**

Medicine	Dose (How much do you take?)	Route (How do you take it?)	Schedule (How often do you take?)	Doctor who prescribed it?	Last taken?	Continue taking on release from the hospital those checked "yes" in shaded column.	Special Instructions.
						<input type="checkbox"/> yes <input type="checkbox"/> no	
						<input type="checkbox"/> yes <input type="checkbox"/> no	
						<input type="checkbox"/> yes <input type="checkbox"/> no	
						<input type="checkbox"/> yes <input type="checkbox"/> no	
						<input type="checkbox"/> yes <input type="checkbox"/> no	
						<input type="checkbox"/> yes <input type="checkbox"/> no	
						<input type="checkbox"/> yes <input type="checkbox"/> no	
						<input type="checkbox"/> yes <input type="checkbox"/> no	
						<input type="checkbox"/> yes <input type="checkbox"/> no	
						<input type="checkbox"/> yes <input type="checkbox"/> no	
<b>Medications added during hospital stay</b>							
						<input type="checkbox"/> yes <input type="checkbox"/> no	
						<input type="checkbox"/> yes <input type="checkbox"/> no	
						<input type="checkbox"/> yes <input type="checkbox"/> no	

The medication list is intended to be a complete record of medications to take upon release from the hospital. Continue taking all medications checked "yes" in the shaded column. This record is based upon the information provided by you and your family members upon admission and any new medications added as a result of this hospitalization. Questions regarding any medications should be directed to the prescribing physician.

\_\_\_\_\_  
Admission Nurse signature/date

\_\_\_\_\_  
Discharge Nurse signature/date

\_\_\_\_\_  
Patient acknowledgement

Continued from Page 1

Medicine	Dose (How much do you take?)	Route (How do you take it?)	Schedule (How often do you take?)	Doctor who prescribed it?	Last Taken?	Continue taking on release from the hospital those checked "yes" in shaded column.	Special Instructions
						<input type="checkbox"/> yes <input type="checkbox"/> no	
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Discharge Nurse signature/date

Patient acknowledgement