

## SIBLEY MEMORIAL HOSPITAL PATIENT MEDICATION LIST

PATIENT LABEL

PATIENT OR FAMILY: Please list all medications you are currently taking. Include all prescription medications, over the counter								
medications, supplements, eye drops, and or herbals.								
Person Completing Form (print name):			Relationship to Patient:					
□ No Medications □ Unable to obtain history, reason:								
□ No Known Allergies	List Allergies to drugs and reaction, food and reaction, and if allergic to latex:							
Vaccine/other History: Check (√) all vaccines received and list date if known. □ Vaccine history not known □ Pneumonia vaccine/Date: □ Influenza vaccine/Date: □ Rhogam/Date:								
MEDICATION NAME: (WRITE LEGIBLY)				Dose		Route Frequency Last Dose		
Attach to form: □Patient list □Facility list			(mg, mcg, other)		(oral, other)	(how often)	(date/time)	
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2)					_		200	
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Information Source (circle): Patient Family MD List Container Pharmacy EMS Other: For any updates, complete and attach additional PATIENT MEDICATION LIST								
MEDICATIONS AT DISCHARGE: *OUTPATIENT ONLY* PATIENT TO BRING THIS COPY OF								
□ Copy of medication prescriptions placed in medical record, originals to patient  INSTRUCTIONS TO NEXT PROVIDER								
New medication at discharge, change in prior medication prescribed, or special instructions:    Medication								
Wiedication		Dose	Route F		quency	mad actions, it appricable		
				_				
Patient/Family/Power of Attorney Physician/LIP/Pharmacist								
Signatura. Date/Timer								
Nursing Date Time.				Signature/Authentication:				
Signature:Date/Time:				Date:				
Signature:Date/Time: Date: Time:								



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