Naval Hospital Bremerton

Medication List Verification Form

List below all of the patient's medications prior to admission; home prescriptions, over the counter medications, herbal supplements and nutraceuticals. New medications or medication changes should be written on admission orders.

Source of Medication List: (check all used)

ALLERGIES: (specify reaction)

☐ **Patient/Family recall** ☐ **Patient medication list** ☐ **CHCS _____** ☐ **History and Physical**
☐ **Previous discharge paperwork** ☐ **Medication Administration Record from facility** ☐ **Other: _____**

☐ **CHECK HERE IF THIS IS AN ADDENDUM TO OR REVISION OF PREVIOUSLY COMPLETED MEDICATION LIST**

Medication Name (Write legibly)	Dose (mg, mcg)	Route (PO, IV, SC)	Frequency (Daily, Every other day)	Last Dose Date/Time
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

See reverse side for additional medication list

Signature of RN Verifying/Obtaining Medication History: _____Print Name:_____ Date/Time:_____

Admitting MD Signature: _____ Print Name (or stamp): _____ Date/Time: _____
(Reconcile within 24 hours of admission)

Upon TRANSFER to another Ward/Service, I have reconciled patients medications with the MAR (RN or MD only)

Signature:_____ Print Name (or stamp):_____Date/Time:_____

If patient is transferred to another service (i.e. From the ICU to MS5)

Upon TRANSFER to another Ward/Service, I have reconciled patients medications with the MAR (RN or MD only)

Signature:_____ Print Name (or stamp):_____Date/Time:_____

Upon DISCHARGE I have reconciled the patient's medications

Discharging MD Signature:_____ Print Name (or stamp):_____Date/Time:_____

Patient identification/Addressograph:

File under Doctors Orders.

Medication list continued

Medication Name (Write legibly)	**Dose (mg, mcg)**	**Route (PO, IV, SC)**	**Frequency (Daily, Every other day)**	**Last Dose Date/Time**
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				

Remarks: