INNOVIS HEALTH – FORM
ADMISSION MEDICATION ORDERS AND RECONCILIATION FORM

Allergies ☐ None ☐ **Allergy Band On** ❍ **Add food allergies to diet order**

Medication/Food:	**Type of Reaction:**	**Medication/Food:**	**Type of Reaction:**

Height _____ inches Weight _____ kg Pregnant: ☐ Yes ☐ No Lactating: ☐ Yes ☐ No

Influenza Immunization (10-1 to 3-1) ☐ Yes when: _____ ☐ No ☐ Unknown ☐ Refused

Pneumococcal Immunization ☐ Yes when: _____ ☐ No ☐ Unknown ☐ Refused

☐ Patient unable to list current medications; no other source available.

INCLUDE ALL HOME MEDS: insulin, eye drops, supplements, aspirin, inhalers, warfarin, herbals, OTCs, samples and transdermal patches

MEDICATION / STRENGTH (Indicate if transfer med)	**DOSE (Amount)**	**ROUTE**	**HOW OFTEN**	**PURPOSE** (per patient or if known)	**DATE/TIME LAST DOSE**	**PHYSICIAN ORDER Y= yes continue N= no discontinue**
						Y N
						Y N
						Y N
						Y N
						Y N
						Y N
						Y N
						Y N
						Y N
						Y N
						Y N
						Y N
						Y N
						Y N
						Y N
						Y N
						Y N
						Y N
						Y N

Patient brought medications to hospital? ☐ Yes ☐ No **Medications sent:** ☐ Pharmacy ☐ Home

Source of Medication List (✓ all that apply): ☐ Patient ☐ Family ☐ Transfer records ☐ Recent history & physical
☐ Pharmacy / Rx vials ☐ Nursing home ☐ Medication Card ☐ Home Pharmacy name / # _____

COMMENTS: _____

Time _____ Date _____ Nurse signature _____

Time _____ Date _____ Pharmacist signature _____

Time: _____ **Date** _____ **Physician Signature:** _____

***High risk medications**: *insulin, oral hypoglycemic, antiseizure, antirejection, and antithrombotic medications* will be reviewed by the RN and relayed to physician within 6 hours of admission.

PATIENT LABEL HERE