AdaCountyParamedics
We're in it for Life!
Community Paramedics

Medication reconciliation

Community Paramedic Line (208)287-2998

☐ **Medication reconciliation** ☐ **Medication list**

Pt Name:	**ID Number / DOB:** **Date / /**

Community Paramedic

Medication Hx recorded by:_____	**ADA # _____**

Source of medication list (check all that apply)

Patient Medication list	**Patient recall**	**Family Recall**	**Pharmacy: _____**
PCP list	**Discharge paperwork**	**Med. Admin. Record**	**Bottles**

Prescription Medications

Medication Name	Dose	Frequency	Reason	Spec. Instruct?	Prescr. MD	Exp. Date	Discrepancy
1.						/	Y N
2.						/	Y N
3.						/	Y N
4.						/	Y N
5.						/	Y N
6.						/	Y N
7.						/	Y N
8.						/	Y N
9.						/	Y N
10.						/	Y N
11.						/	Y N
12.						/	Y N
13.						/	Y N
14.						/	Y N
15.						/	Y N
16.						/	Y N
17.						/	Y N
18.						/	Y N
19.						/	Y N
20.						/	Y N
21.						/	Y N
22.						/	Y N
23.						/	Y N
24.						/	Y N
25.						/	Y N

DRAFT

Allergies

Substance	Reaction	Substance	Reaction

Contact Information

Doctor's Name:_____ **Doctor's Phone: (____)**_____

Pharmacy Name:_____ **Pharmacy Number: (____)**_____

Emergency Contact Name: _____ **Phone: (____)**_____

This medication reconciliation form has been described and with the pt's full understanding. All recommendations by the Community Paramedic are understood and will be followed to the best of their ability. Any medications found that are not currently recommended by the pt's primary physician will be reported back to the primary care physician with further instructions.

Pt Signature: **CP Signature:**

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