CROZER KEYSTONE HEALTH SYSTEM

☐ CROZER
☐ DCMH
☐ COMMUNITY HOSPITAL
☐ SPRINGFIELD HOSPITAL
☐ TAYLOR HOSPITAL

ME0020

PATIENT NAME: _____

MEDICAL RECORD NUMBER: _____

DATE OF BIRTH: _____

Patient Label

MEDICATION COORDINATION BOOKLET
HOME MEDICATIONS

☐ **Additional Form Required -** _____ **of** _____

☐ **No Medications at this time** ☐ **Unable to obtain at this time** ☐ **Pharmacy phone number if known:** _____ ☐ **Unknown**

Source of Medication List (check all that apply)

☐ Patient Medication List/Card ☐ Patient/Family Recall ☐ Prescription Bottle ☐ Pharmacy _____ ☐ Primary Care Physician List

☐ Previous Discharge Paperwork ☐ Medication Administration Record from Another Facility ☐ Other _____

Home Medication(s) (Include prescriptions, herbal, over the counter, dietary supplements)	**Dose**	**Route**	**Frequency**	**Reason**	**Last Home Dose**	**Discharge Purpose Only** **Next Home Dose**	**Resume at Discharge** **Yes**	**No**
ADDITIONAL MEDICATIONS AT TIME OF DISCHARGE								

PNEUMONIA VACCINE given (DATE): _____ **FLU VACCINE** given (DATE): _____

OTHER VACCINE _____ given (DATE): _____

DATE: _____ TIME: _____ ADMITTING CLINICIAN/TITLE: _____

Additional Instructions: _____

I have received and understand the above instructions.

PATIENT/RESPONSIBILITY PARTY: _____ DATE: _____

I have reviewed the current medications list and reconciled it with current orders.

DATE: _____ TIME: _____ DISCHARGE PHYSICIAN: _____

DATE: _____ TIME: _____ DISCHARGE NURSE: _____