Outpatient Medication Reconciliation and Treatment Form

Instructions: Complete this form during the outpatient visit to reconcile pre-existing medications with newly prescribed treatments. Provide a copy to the patient and retain the original in the medical record.

Patient Information

Patient Full Name:		**Date of Birth (MM/DD/YYYY):**	
Medical Record Number (MRN):		**Date of Reconciliation:**	
Allergies / Adverse Reactions:			

Medication Reconciliation Table

List all current medications (prescriptions, over-the-counter, and herbal supplements) and indicate the reconciliation action.

Medication Name & Strength	Dosage & Route	Frequency	Last Dose Taken (Date/Time)	Action (Continue / Stop / Modify)	New / Modified Instructions

New Outpatient Prescriptions / Treatment Plan

New Medication Name & Strength	Dosage, Route, & Frequency	Quantity / Refills	Indications / Special Instructions

Follow-Up Care and Instructions

Next Scheduled Appointment:		**Provider / Clinic Name:**	
Special Instructions:			

Signatures and Verification

By signing below, the clinician verifies that medication reconciliation has been performed, and the patient/caregiver acknowledges receipt and understanding of the updated medication plan.

Physician / Provider Signature:		**Date:**	
Nurse / Reconciler Signature:		**Date:**	
Patient / Caregiver Signature:		**Date:**	