

McLaren Print System Order

Order No: 46108
 Order Date: 2019-06-10
 User: Lisa Jaeger
 Phone: 586-493-2236

Ship Location: McLaren Macomb Attn: Lisa Jaeger, LL Multimedia Services
 1000 Harrington Blvd.
 Mount Clemens, MI 48043

Forms

Quantity: 500
 Paragon Dept No: 40110
 Dept Name: Respiratory Care & Neurology Serv
 Company Number: 260

Order Total Price: 18.00

Item Number: 17762-B
 Item Description: Medication Reconciliation Report (Macomb)
 Revision Date: 6/2019
 Print: 1 sided black and white
 Paper: 20# White Text
 Size: 8.5 x 11
 Fold:
 Finish: None
 Drill: 5 Hole Top
 Misc Info: ss; black & white; 20#

McLaren Macomb
 Outpatient Pulmonary Rehabilitation Program
MEDICATION RECONCILIATION REPORT

Entry Assessment by: _____ MFT Date: _____

Drug Allergies		Food Allergies		Other Allergies	
<input type="checkbox"/> No known drug allergies		<input type="checkbox"/> No known food allergies		<input type="checkbox"/> No other known allergies	
1. _____	2. _____	1. _____	2. _____	1. Latex: <input type="checkbox"/> YES <input type="checkbox"/> NO	
3. _____	4. _____	3. _____	4. _____	5. _____	
Reaction: _____		Reaction: _____		Reaction: _____	

Name of Medicine Source of Rx	Initial Dose	Initial Frequency	Compared to	Change/Date Made	Continue at Discharge
Pulmonary Medications					
1. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
2. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
3. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
4. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
5. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
6. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
Cardiovascular Medications					
<input type="checkbox"/> Not on routine					
1. Anti-clot =			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
2. ACE / AFB =			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Beta Blocker =			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
4. Chd / Stat =			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
5. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
6. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
Other Physician Prescribed Medications					
1. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
2. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
3. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
4. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
5. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
6. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
7. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
8. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
9. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
10. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
11. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
Spec Info: Vitamins, OTC, Vitamins, Minerals, Herb					
1. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
2. _____			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO

Exit Assessment by: _____ MFT Date: _____

Copied to: Patient Physician Other

MEDICATION RECONCILIATION REPORT
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