ADMISSION MEDICATION RECONCILIATION AND ORDER FORM

Contra Costa Regional Medical Center

Patient: [redacted] **MR#** [redacted]

DOB: [redacted] **SEX:** M

Allergies/ADRs:
PROMETHAZINE HCL,PENICILLINS

Review Home Med List Below 1) Line through any med not being taken at home. 2) If med is taken at home, modify sig as needed.	C = CONTINUE DC = DISCONT. M = MODIFY	If any changes for inpatient order, specify modifications.

	C	DC	M	SPECIFY MODIFICATIONS

H O M E M E D I C A T I O N L I S T / O R D E R S

Alumin & Mag Hydrox Antacid, 1 TAB (Maalox) 4 TIMES A DAY AFTER MEALS — 2 TAB CHEW	Prescribed: 10/29/07				
Aspirin Ec, 81 MG (Aspirin Ec) 81 MG PO DAILY	Reported: 01/02/06				
Calcitriol, 0.5 MCG (Rocaltrol) DAILY — 0.5 MCG BY MOUTH 1 TAB QID	Reported: 01/21/08				
Calcium Carbonate, 500 MG (Oyst-Cal) 500 MG PO BID	Reported: 10/11/06				
Flunisolide Nasal Spray, 0.025 % (Nasalide/Nasarel Nasal Spray) TWICE A DAY — 1 - 2 SPRAYS IN EACH NOSTRIL For Hay Fever	Prescribed: 02/07/08				
Hydroxyzine Hcl, 25 MG (Atarax) EVERY 4 TO 6 HOURS — 25 MG BY MOUTH **NEEDS REFILL FOR THIS MEDICATION*	Reported: 01/21/08				
Levothyroxine Sodium, 0.125 MG (Synthroid) DAILY — 0.125 MG BY MOUTH 2 TABS QAM	Reported: 01/21/08				

Provider Signature _____

ORIGINAL IN ORDER SECTION, COPY IN H&P SECTION ********** Continued on Page 2**********

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H O M E M E D I C A T I O N L I S T / O R D E R S

Metoprolol Succinate Er, 25 MG (Toprol Xl) DAILY 25 MG BY MOUTH KATZMAN MD FF:08/28/07 LF:05/21/08 REFILL AUTH 06/17/08 EVO RPH FAX TO LONGS 798-2899 Reported: 06/17/08				
Omeprazole Otc, 20 MG (Prilosec Otc) DAILY 20 MG BY MOUTH Prescribed: 10/29/07				
Ondansetron, 4 MG (Zofran) THREE TIMES A DAY 4 MG BY MOUTH Prescribed: 06/16/08				
Pravastatin, 10 MG (Pravachol) DAILY 10 MG BY MOUTH For Cholesterol Prescribed: 12/18/07				
Sucralfate, 1 GM (Carafate) 1 GM CHEW AC&HS TAB Reported: 10/25/05				

Provider Signature _____

ORIGINAL IN ORDER SECTION, COPY IN H&P SECTION ********** Continued on Page 3**********

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H O M E M E D I C A T I O N L I S T / O R D E R S

Check here if patient is pregnant [ ]

Provider Signature _____ Date/Time _____
Transcribed by (clerk) _____ Date/Time _____
Noted by (RN) _____ Date/Time _____

ORIGINAL IN ORDER SECTION, COPY IN H&P SECTION ********* FINAL PAGE OF REPORT *********