MEDICATION RECONCILIATION UPON READMISSION TO ASSISTED LIVING FACILITY

(PLEASE FAX THIS SIGNED FORM BACK TO NURSE OFFICE)

FAX:_____

PHONE:_____

The resident stated below was recently discharged from the hospital on **(Date)** _____ and readmitted to our Assisted Living Facility on **(Date)** _____. Below is a list of the resident's medications to be reconciled prior to administration of all medications.

Resident Name:_____ **D.O.B. _____**

Medication Allergies:_____ **Code Status:_____**

Medication & Dose	Time Medication Administered	Route	Continue OR Discontinue therapy? (circle)	NEW Change to medication listed: **(Provider use only)**
			C : DC	
			C : DC	
			C : DC	
			C : DC	
			C : DC	
			C : DC	
			C : DC	
			C : DC	
			C : DC	
			C : DC	
			C : DC	
			C : DC	

Please note by signing this document you are allowing Extended Pharmacy up to 12 refills on all medications, unless specified

Provider Signature:_____/**NPI#:_____/**Date:_____

Nurse Name:_____/Signature:_____/Date:_____

***Once this form has been signed by a Provider, all medications will have been reconciled. Please return this form back to the facility via fax number listed above.**

(Staff Nurse at facility will be required to fax this form to Extended Living Pharmacy upon response from Provider)

EXTENDED pharmacy™