AAAHC
ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

Patient Medication Reconciliation Form in Primary Care Setting

Patient Name: _____ Patient Preferred Pharmacy Name/Phone #: _____

Source of Medication List *(Check All That Apply)*: ❑ Patient Interview ❑ Patient's Own List ❑ Caregiver Interview ❑ Pharmacy
❑ State Prescription Drug Monitoring Program (POMP) ❑ Primary Care Provider ❑ Surgeon ❑ Other, please specify: _____

Allergies (include drug and materials)	Reaction

Routinely Taken Medications (includes OTC)	Dispensing Pharmacy (if different from pharmacy listed at top of form)	Dose	Frequency	Indication	Start Date	Prescriber	Medication (Continue=C, Discontinue=D, New=N)	Comments

Patient Signature: _____ Date: _____

Provider Completing Form: _____ Date: _____

**NOTE: IF THERE ARE ANY DISCREPANCIES IN THIS FORM COMPARED TO INFORMATION CONTAINED IN THE PATIENT'S MEDICAL RECORD, RESOLVE THE ISSUES BY CONTACTING THE PHARMACY, PRESCRIBING PHYSICAN, AND/OR THE PATIENT.