OUTPATIENT HOME MEDICATION RECORD

PLEASE LIST BELOW what medications your doctor(s) prescribe for you. Include what you take on your own—for example, medicines for fever, aches, pain, coughs, colds; allergy relief; vitamins; herbal products (such as gingko biloba, fish oil, chondroitin, glucosamine, etc.) Also list nutrition supplements such as Boost, Glucerna, etc.

Signature of person completing form: ________________________________

List completed by: □ Patient  Other: Name ________________________________________________________________
                    Relationship: _____________________________

If you have more than one test scheduled for today, please ask for a copy of this form to take with you to the next test location.

KEEPING TRACK OF YOUR MEDICATIONS:
Having all of your medicines written down in one place helps your doctor, pharmacist, or other health care workers take better care of you.

• Keep a list like this one to track medication names, doses, and how often you take them.
• If your medicines or doses change, or new ones are added, add these changes to the list
• Always keep the list with you to show your doctor or other healthcare workers, or in case of an emergency.

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose</th>
<th>How Often</th>
<th>Route taken by mouth, injection, put on skin, other (please describe)</th>
<th>For Staff Use</th>
<th>Comment:</th>
<th>Sign:</th>
<th>Date:</th>
<th>Time:</th>
</tr>
</thead>
<tbody>
<tr>
<td>I do not take any Home Medications</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I have reviewed the patient’s medication information:

<table>
<thead>
<tr>
<th>Location</th>
<th>Registration</th>
<th>Signature</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
</table>

Unable to obtain home medication list at this time.

Comment: ______________________________________________________

Sign: _____________________________

Date: _____________________________

Time: _____________________________