SK Discharge/Transfer Medication Reconciliation Form

Saskatchewan Health Authority

Label/Address

Location: _____

Allergies:

Prescription - Discharge to Home ☐ | **Prescription - Discharge to LTC** ☐ | **Transfer Medication List - External** ☐ **Transfer Orders - Internal** ☐

Community Pharmacist: For refills beyond what is listed below, please contact family physician/nurse practitioner.

Prescriber/Community Pharmacist: "No Rx Needed" in the following tables implies medication patient was taking prior to admission has not changed (dose, route, frequency) and patient has supply, refills on file OR product can be acquired without a prescription (i.e. over the counter medication)

1. Active Inpatient Medications

Review MAR and prescriber order sheets for last 72hrs

Scheduled medications, followed by PRN active prior to discharge

Medication	Dose / Route / Frequency	Medication Status: Same as prior to admission	Medication Status: Adjusted in hosptial	Medication Status: New in hospital	Comments / Rationale / Indication	Prescriber Orders: Continue	Prescriber Orders: Quantity (Discharge Only)	Prescriber Orders: Refills (Discharge Only)	Prescriber Orders: No Rx Needed	Prescriber Orders: STOP
							☐1 month Or			
							☐1 month Or			
							☐1 month Or			
							☐1 month Or			
							☐1 month Or			
							☐1 month Or			
							☐1 month Or			
							☐1 month Or			
							☐1 month Or			
							☐1 month Or			
							☐1 month Or			

Also add written quantity for narcotics, controlled substances, benzodiazepines, and gabapentin

Completed by: Signature Title

Date: Time:

Reviewed by: Signature Title

Date: Time:

Authorized Prescriber: **#:** _____

(print)

(sign)

Phone #:

Date:

Prescriber Address for orders for narcotics, controlled substances, benzodiazepines, and gabapentin

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2. Pre-admission medications as listed on Best Possible Medication History		**Prescriber Orders**				
		Also add written quantity for narcotics, controlled substances, benzodiazepines, and gabapentin				
RESTART pre-admission medications not ordered or stopped in hospital STOP pre-admission medications no longer required Medication Dose / Route / Frequency	Comments / Rationale / Indication	**Restart**	Quantity **Discharge Only**	Refills **Discharge Only**	No Rx Needed	**STOP**
			☐1 month Or			
			☐1 month Or			
			☐1 month Or			
			☐1 month Or			
			☐1 month Or			
			☐1 month Or			
			☐1 month Or			

3. NEW medications to START after discharge		**Prescriber Orders**	
		Also add written quantity for narcotics, controlled substances, benzodiazepines, and gabapentin	
Medication Dose / Route / Frequency	Comments / Rationale / Indication	Quantity **Discharge Only**	Refills **Discharge Only**
		☐1 month Or	
		☐1 month Or	
		☐1 month Or	
		☐1 month Or	
		☐1 month Or	
		☐1 month Or	

Completed by: Signature Title

Date: Time:

Reviewed by: Signature Title

Date: Time:

Authorized Prescriber: **#:** _____

(print)

(sign)

Phone #:

Date:

Prescriber Address for orders for narcotics, controlled substances, benzodiazepines, and gabapentin

CONFIDENTIALITY NOTICE: *The content of the communication is confidential and contains personal health information. It is intended solely for the use of the patient's health care providers.* ***If you have received this communication in error, immediately notify the sender by return fax*** *and destroy all originals and copies of the misdirected communication.*

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3. NEW medications to START after discharge (continued)			**Prescriber Orders**	
			Also add written quantity for narcotics, controlled substances, benzodiazepines, and gabapentin	
Medication	Dose / Route / Frequency	Comments / Rationale / Indication	Quantity **Discharge Only**	Refills **Discharge Only**
			☐ 1 month Or	
			☐ 1 month Or	
			☐ 1 month Or	
			☐ 1 month Or	
			☐ 1 month Or	
			☐ 1 month Or	

Other Medication Instructions/Comments:

Copied/Faxed to:	Name of Recipient / Fax #	Date	Copied/Faxed to:	Name of Recipient / Fax #	Date
☐ Community Pharmacy			☐ Receiving Facility		
☐ Long Term Care			☐ Family Physician/ Nurse Practitioner		
☐ Home Care			☐ Other ☐ Copy to patient		

Please note: If faxed to Community Pharmacy, stamp original FAXED and retain in chart.

Completed by: _____ Signature _____ Title

Date: _____ Time: _____

Reviewed by: _____ Signature _____ Title

Date: _____ Time: _____

Authorized Prescriber: **#:** _____

_____ (print)

_____ (sign)

Phone #: _____

Date: _____

Prescriber Address for orders for narcotics, controlled substances, benzodiazepines, and gabapentin