

SK Discharge/Transfer Medication Reconciliation Form
Saskatchewan Health Authority

Location: SHA VIC 2ICU 2-1

Vacation, Mexico

Age: 27 yrs HSN: 103432353
DOB: 21/02/1991 MRN: 006240653
Gender: M Admitted: Jan 29, 2018

Allergies: No Known Drug Allergy	Patient Address:
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Prescription - Discharge to Home ☐	Prescription - Discharge to LTC ☐	Transfer Medication List - External ☐ Transfer Orders - Internal ☐
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Community Pharmacists: For refills beyond what is listed below, please contact family physician/nurse practitioner.

1. Active Inpatient Medications		Medication Status			Prescriber Orders					
Review MAR and prescriber order sheets for last 72hrs		Same as prior to admission	Adjusted in hospital	New in hospital	Comments / Rationale / Indication	Continue	Quantity Discharge Only	Refills Discharge Only	No Rx Needed	STOP
Medication	Dose / Route / Frequency									
Scheduled Medications: followed by PRN active prior to discharge										
CLOPIDOGREL BISULFATE tab 75 MG (PLAVIX)	75 MG (1 TAB) PO DAILY Sched: 09:00						☐ 1/12 Or			
PRN Medications:										
ACETAMINOPHEN tab 325 mg	325 MG (1 TAB) PO Q6H PRN *MAX 4G TOTAL ACETAMINOPHEN PER 24 HOURS*						☐ 1/12 Or			
dimenhyDRINATE tab 50 mg	50 MG (1 TAB) PO Q4H PRN						☐ 1/12 Or			
Medications Ordered After Time of Printing:										
							☐ 1/12 Or			
							☐ 1/12 Or			
							☐ 1/12 Or			
							☐ 1/12 Or			
							☐ 1/12 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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2. Pre-admission medications as listed on Best Possible Medication History		Prescriber Orders					
RESTART pre-admission medications not ordered or stopped in hospital STOP pre-admission medications no longer required		Also add written quantity for narcotics, controlled substances, benzodiazepines, and gabapentin					
Medication	Dose / Route / Frequency	Comments / Rationale / Indication	Restart	Quantity Discharge Only	Refills Discharge Only	No Rx Needed	STOP
COUMADIN 2 MG TABLET	take one tablet DAILY		☐	1/12 Or			
GABAPENTIN 300 MG CAPSULE	take one capsule THREE TIMES DAILY		☐	1/12 Or			
GABAPENTIN 400 MG CAPSULE	take one capsule THREE TIMES DAILY		☐	1/12 Or			
COUMADIN 1 MG TABLET	take one tablet once DAILY		☐	1/12 Or			
COUMADIN 4 MG TABLET	take one tablet once DAILY		☐	1/12 Or			
ELAVIL 10 MG TABLET	take 4 tablets AT BEDTIME		☐	1/12 Or			
TEVA-NITROFURANTOIN 50 MG CAP	take one capsule DAILY		☐	1/12 Or			
			☐	1/12 Or			
			☐	1/12 Or			
			☐	1/12 Or			
			☐	1/12 Or			
			☐	1/12 Or			
			☐	1/12 Or			
			☐	1/12 Or			
			☐	1/12 Or			

Completed by: _____ Signature _____ Title _____

Date: _____ Time: _____

Reviewed by: _____ Signature _____ Title _____

Date: _____ Time: _____

Authorized Prescriber:	#:	_____
		(print)
Phone #:		(sign)
Date:		_____
Prescriber Address for orders for narcotics, controlled substances, benzodiazepines, and gabapentin		

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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
			☐ 1/12 Or	
			☐ 1/12 Or	
			☐ 1/12 Or	
			☐ 1/12 Or	
			☐ 1/12 Or	
			☐ 1/12 Or	
			☐ 1/12 Or	
			☐ 1/12 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)	
Phone #:	(sign)

Date:	_____
Prescriber Address for orders for narcotics, controlled substances, benzodiazepines, and gabapentin	

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