



THE CENTER IS YOU



60601572

SAUNDERS, KEVIN E
Darling MD, James L.
UC

DOB 05/01/56 53



0597460

Outpatient Medication Reconciliation Physician Order Form

Check if patient is not on any home medications, no further signatures required.

Height 5'7" Weight: 170 lbs

Date of Visit: 4/28/10
Information Source: Patient / Family* Pharmacy PCP
 Other: _____

Allergies: No Known Allergies
Amputation - make him
Nauseated.

Vaccine / Year: Influenza _____ Pneumococcal: _____
Td: _____ Other: _____

Recorded By: [Signature] RN / PA

Date: 4/28/10 Time: 1524

* Patients must be consulted for current medications. If unable, consult family, primary care provider (PCP), or Pharmacy.

CURRENT MEDICATIONS								
PRESCRIPTION / HERBAL / OTC MEDICATION NAME	DOSE	ROUTE	FREQUENCY	LAST TAKEN	CONTINUE			
					ON ADMISSION		ON DISCHARGE	
					YES	NO	YES	NO
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.	<u>[Signature]</u>							
12.								
13.								
14.								
15.								

Please use additional forms as needed.

4/28/10 575h

For Ambulatory Patients Only: I have reviewed the home medication list in relation to today's visit and any medications administered or prescribed for home use. Please continue the patient's medication regimen as prescribed by the patient's other providers and any new or changed medications as prescribed by me.

Physician Signature: [Signature]
Emily Williams, NP

[Signature]
James Darling, MD
MD # 217068
DEA: BD1696814

Date: 4/28/10 Time: 1540

NEW MEDICATIONS					
MEDICATION NAME	DOSE	ROUTE	FREQUENCY	FOR HOW LONG?	
1. <u>Drochlorperazine</u>	<u>10mg</u>	<u>PO</u>	<u>q 6-8</u>	<u>per</u>	
2.					
3.					
4.					
5.					

Additional Information

White - Chart Canary - Patient