1st American Choice Home Services LLC

MEDICATION PROFILE

PATIENT _____ PHARMACY _____
PATIENT ID # _____ ADDRESS _____
PHYSICIAN _____ PHONE _____
PATIENT'S Date Of Birth _____ HEIGHT_____ WEIGHT_____
ALLERGIES ☐ NKA ☐ YES, list: _____
Does patient have a past history of medication compliance? ☐ NO ☐ YES
Has patient had any adverse drug reaction in the past? ☐ NO ☐ YES, list: _____

DATE Med started	**DRUG**	**DOSE**	**ROUTE**	**(N) NEW OR (C) CHANGE**	**COMMENTS/ Reason for PRN**	**D/C DATE**	**SIGNATURE** tovalidate Discontinuation of Med date

Check Frequency: ☐Once daily ☐Twice daily ☐Three times daily ☐Four times daily ☐Every other day Every ☐4 ☐6 ☐8 ☐12 hours ☐At bedtime ☐With meals ☐ PRN ☐Other

Check Frequency: ☐Once daily ☐Twice daily ☐Three times daily ☐Four times daily ☐Every other day Every ☐4 ☐6 ☐8 ☐12 hours ☐At bedtime ☐With meals ☐ PRN ☐Other

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	OXYGEN	at _____ lpm via ❑ NC ❑ Mask ❑ Vent ❑ continuous ❑ PRN dyspnea ❑ at hour of sleep

With my signature/date I verify:

1. I have reviewed the above medications to identify any potential adverse effects and drug reactions including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy and non-compliance.
2. That the above medications (prescribed/OTC/sample, herbal and/or home remedies) have been reconciled with physician orders.

SIGNATURE/DATE SIGNATURE/DATE

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