OUR LADY OF THE LAKE SURGICAL HOSPITAL
PATIENT MEDICATION RECORD

*If patient medication list is longer than space provided, please use 2nd sheet
White background area to be completed on admission
Gray background area to be completed on discharge

Ht. __________ Wt. _________ Lactating ____Yes ____No Pregnant ____Yes ____No

Prior to Arrival — MEDICATION Taken at Home (also include Vitamins, Herbal, and other Over the Counter Medication)						During Hospitalization — HOME MEDICATION		On Discharge — Continue HOME MEDICATIONS				
MEDICATION Ordering Physician	DOSE	FREQUENCY	LAST DOSE DATE/TIME		Reason for Med	Cont. during hospitalization?		Cont. on Discharge		DOSE	FREQUENCY	Next Dose Due
ASPIRIN Yes No		______ times per day other____________				yes	no	yes	no		______ times per day other____________	
		______ times per day other____________				yes	no	yes	no		______ times per day other____________	
		______ times per day other____________				yes	no	yes	no		______ times per day other____________	
		______ times per day other____________				yes	no	yes	no		______ times per day other____________	
		______ times per day other____________				yes	no	yes	no		______ times per day other____________	
		______ times per day other____________				yes	no	yes	no		______ times per day other____________	
		______ times per day other____________				yes	no	yes	no		______ times per day other____________	
		______ times per day other____________				yes	no	yes	no		______ times per day other____________	
		______ times per day other____________				yes	no	yes	no		______ times per day other____________	
		______ times per day other____________				yes	no	yes	no		______ times per day other____________	
		______ times per day other____________				yes	no	yes	no		______ times per day other____________	
		______ times per day other____________				yes	no	yes	no		______ times per day other____________	

MEDICATION/FOOD ALLERGIES
NAME
REACTION
NAME
REACTION
NAME
REACTION
NAME
REACTION
NAME
REACTION
NAME
REACTION
NAME
REACTION

NEW MEDICATIONS ON DISCHARGE			
MEDICATION	DOSE	FREQUENCY	Reason for Med
		__________times per day other____________________	
		__________times per day other____________________	
		__________times per day other____________________	
		__________times per day other____________________	

Physician Signature_________________________________ Date/Time____________________

This is a complete list of the patient's medicines: Yes No

Who provided the medication information?_______________________________________

A member of the patient's family will bring a list: Yes No

Name:____ Phone No: ____________________

Signature of Nurse admitting patient ____ Date

Signature of Nurse discharging patient ____ Date

Patient Acknowledgment ____ Date

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PATIENT MEDICATION RECORD

Patient Label

OLOLSH NUR003 02/21

White - Chart Yellow - Patient