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| **Interventions** | |
| Healthcare Provider | Result |
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| **Discharge Medications** | | | | |
| Name of Medication | Dose | Directions | Quantity | Indication |
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Patient Name: DOB: Phone #:

Emergency Contact: Relation: Phone #:

Primary Physician: Next Appointment:

Allergies/ Intolerances:

Disease States:

Discharging Facility Information

Facility: Phone #:

Attending: Date Admitted: Date Discharged:

Reason for Admittance:

Pharmacy Info

Patient Name: Date:

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| **Daily Medications:** The medications you were already taking plus any new medication that you will take continuously. (May continue on attached sheet of paper) | | | |
| Name of Medication | Dose | How should I take it? | What am I taking it for? |
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| **Temporary Medications:** Any medication that you will take for a short period of time. | | | |
| Name of Medication | Dose | How should I take it and for how long? | What am I taking it for? |
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| **Discontinued Medications:** Medications that you either need to stop taking or have already stopped taking. | | | |
| Name of Medication | Dose | Should I start taking this medication again at a later date? | Who discontinued? |
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Brenna Neumann, Pharm. D.

Pharmacist Signature Date

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| **Daily Medications:** The medication you were already taking plus any new medication that you will take continuously. | | | |
| Name of Medication | Dose | How should I take it? | What am I taking it for? |
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| **Temporary Medications:** Any medication that you will take for a short period of time. | | | |
| Name of Medication | Dose | How should I take it and for how long? | What am I taking it for? |
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| **Discontinued Medications:** Medications that you either need to stop taking or have already stopped taking. | | | |
| Name of Medication | Dose | Should I start taking this medication again at a later date? | Who discontinued? |
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Medication List Continued…

Patient Name: DOB:

Updated On:

Pharmacy Info

Medication List

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| **Chronic Medications** | | | | | | |
| Name of Medication | Dose | Directions | Quantity | Last Fill | Prescriber | Indication |
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\*\*\*\* Continued on Back\*\*\*\*

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| **Short Term Medications** | | | | |
| Name of Medication | Dose | Directions & Duration | Prescriber | Indication |
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| **Discontinued Medications** | | | | |
| Name of Medication | Dose | Authorizer & Reason | | Date Discontinued |
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Notes:

