Infirmary Health System

INFIRMARY HEALTH SYSTEM
UNIVERSAL MEDICATIONS FORM

Fold this form and keep it in your wallet for easy access

Date form started:

Name:	Date of Birth:
Address:	City, State, Zip:
Phone Number:	Alternative Phone number:
Emergency Contact Name/Phone numbers:	

IMMUNIZATION RECORD (Record the date/year of last dose taken, if known)	
1) PNEUMONIA VACCINE:	4) FLU VACCINE:
2) HEPATITIS VACCINE:	5) OTHER:
3) TETANUS-DIPHTHERIA (TD): (TD - Adult revaccination should occur if you have a clean or minor wound and your last vaccine was more than 10 years ago. For any other wound, you should be revaccinated if your vaccine was more than five years ago. Consult your physician if you are unsure of your last vaccination)	

ALLERGIES / ADVERSE DRUG REACTIONS	**DESCRIBE REACTION**

MEDICAL CONDITIONS

- ❑ asthma
- ❑ diabetes
- ❑ cancer
- ❑ heart disease
- ❑ high blood pressure
- ❑ kidney disease
- ❑ stroke
- ❑ seizure
- ❑ other_____

PRIMARY CARE PHYSICIAN: Name: _____ Phone: _____

OTHER PHYSICIANS: (SPECIALISTS) _____ _____

_____ _____

_____ _____

_____ _____

PHARMACY: _____ _____

Please keep your medication list current

TAKE ONLY THESE MEDICATIONS

CONTACT YOUR PHYSICIAN(S) BEFORE TAKING ANY ADDITIONAL PRESCRIPTIONS, OVER-THE-COUNTER MEDICATIONS, HERBALS OR HOME REMEDIES. TAKE THIS SHEET WITH YOU TO ALL FOLLOW UP APPOINTMENTS

DATE	NEW MED ✓	NEW DOSE ✓	NAME & STRENGTH OF MEDICATION, INCLUDING INHALERS AND NEBULIZERS	HOW TO TAKE MEDICATIONS	WHEN TO TAKE (HOW OFTEN)	DATE/TIME LAST DOSE	DATE/TIME NEXT DOSE DUE	PRESCRIPTION PROVIDED ✓	PRINTED INFORMATION ✓	MEDICATION RELABELED BY PHARMACY ✓	DATE STOPPED

Instructions to patients:

1. ***Date any additions or changes to this form. Draw a single line through medications that are stopped.***
2. ***Draw a single line through medications that have a change in dose or changes in how you take it. Re-write these medications in the next available space.***
3. ***Show this form any time you are asked about medications you take (doctor visits, diagnostic tests, emergency room, hospital, etc.)***
4. ***Continue to update this form as your medications change. Ask your health care provider for assistance with changes or additional forms if needed.***

Comments:_____

_____

I have received and understand the above information.
Discharge Date:_____

Patient/ Significant Other:_____ Nurse:_____

ADDRESSOGRAPH

INFIRMARY HEALTH SYSTEM

Discharge Medication Reconciliation

PS Form# 1010-0014 Rev. 05/2007