CareRx



# Best Possible Medication History Reconciliation / Admission Orders (Digital)

Quantities unless specified otherwise: PRN 31 doses, Rx qs 7 days or pack size of 1. Externals 100g.
Orders authorized ongoing until next Physician's review form signed unless stop date or discontinue order given.

| Date: | Resident | Room | Bed |
|---|---|---|---|
| | | | |

| Facility | Attending Physician | Diet |
|---|---|---|
| | | |

| Allergies | Medical Conditions |
|---|---|
| | |

❑ New Admission ❑ Re-Admission

**Cross Out All Discontinue Orders**

| HOA | Continue (✓) | Discontinue Reason Code (X) | New (✓) |
|---|---|---|---|
| | | | |

Date last given _____ Source _____ ❑ Do Not Send ____ CODE

Date last given _____ Source _____ ❑ Do Not Send ____ CODE

Date last given _____ Source _____ ❑ Do Not Send ____ CODE

Date last given _____ Source _____ ❑ Do Not Send ____ CODE

Date last given _____ Source _____ ❑ Do Not Send ____ CODE

Lab Work Orders:

Leave of absence with responsible party and medications permitted. Yes ❑ No ❑

May use Medical Directives Yes ❑ No ❑

## Billing Information

Gender: M ❑ F ❑ Date of Birth ___ /____ /_____ DD MMM YYYY

1. Health Card Number _____

2. Other Drug Insurance eg. Veterans Affairs, Greenshield, Liberty Health, BCE Emergis, ESI or Other

ID # _____ Carrier # _____

Group # _____ Subscriber _____

**Responsible Party for Finances:**

Name: _____

Address: _____

_____ _____ Postal Code

Phone #: _____ Cell #: _____

## Medication Reconciliation Codes Legend

**Reason for Discontinue**

**A -** Adverse Drug Reaction
**B -** Not Needed
**C -** Changed
**D -** Duplicate Therapy
**E -** No Supporting Diagnosis
**F -** Other (document in progress notes)

**Source of Medication List: (Use at least two) circle**

**G -** CCAC forms **K -** Resident or family recall **L -** Review of vials

**H -** Community Pharmacy _____ Name _____ Tel. #

**I -** Hospital Discharge _____ Hospital Name

**J -** LTC MAR _____ LTCH Name

❑ List recorded by: _____

Nurse Process 1. _____ _____ Date / Time

Nurse Process 2. _____ _____ Date / Time

❑ Telephone order taken by: _____

_____ _____ Prescriber Signature / Registration # Date