



# 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 30g.  
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						
<div>Billing Information</div> <div>Gender: M <input type="checkbox"/> F <input type="checkbox"/> Date of Birth ____ / ____ / ____ DD MMM YYYY</div> <div>Health Card Number</div> <div>Other Drug Insurance eg. Veterans Affairs, Greenshield, Liberty Health, BCE Emergis, ESI or Other</div> <div>ID# _____ Carrier # _____</div> <div>Group# _____ Subscriber _____</div>					<div>Responsible Party for Finances:</div> <div>Name: _____</div> <div>Address: _____</div> <div>_____ Postal Code</div> <div>Phone #: _____ Cell#: _____</div>						
<div>Medication Reconciliation Codes Legend</div> <div>Reason for Discontinue</div> <div>A - Adverse Drug Reaction D - Duplicate Therapy</div> <div>B - Not Needed E - No Supporting Diagnosis</div> <div>C - Changed F - Other (document in progress notes)</div>					<div>Source of Medication List: (Use at least two) circle</div> <div>G - CCAC form K - Resident or family recall L - Review of vials</div> <div>H - Community Pharmacy _____ Name Tel. #</div> <div>I - Hospital Discharge _____ Hospital Name</div> <div>J - LTC MAR _____ LTCH Name</div>						
<input type="checkbox"/> New Admission		HOA	Continue (✓)	Discontinue Reason Code (x)	New (✓)	Cross Out All Discontinue Orders		HOA	Continue (✓)	Discontinue Reason Code (x)	New (✓)
Cross Out All Discontinue Orders											
Date last given _____ Source _____ <input type="checkbox"/> Do Not Send				CODE		Date last given _____ Source _____ <input type="checkbox"/> Do Not Send				CODE	
Lab Work Order:					Lab Work Order:						
Leave of absence with responsible party and medications permitted. Yes <input type="checkbox"/> No <input type="checkbox"/>					May use Medical Directive Yes <input type="checkbox"/> No <input type="checkbox"/>						

☐ List recorded by: \_\_\_\_\_

☐ Telephone order taken by: \_\_\_\_\_

Nurse Process 1. \_\_\_\_\_  
Date / Time

Nurse Process 2. \_\_\_\_\_  
Date / Time

\_\_\_\_\_

Prescriber Signature / Registration # Date

SMART LTC FORMS FEATURING