One On One
MEDICAL CARE

Fresno CA 93722
Ph.: (559) 612-1720
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www.oneononemedcare.com
E-mail: info@oneononemedcare.com
NPI #1851925192

# MEDICATION RECONCILIATION

MR # _____

PATIENT: _____ DATE: _____

DATE OF BIRTH: _____ DRUG ALLERGY: _____ LATEX ALLERGY: _____

PHARMACY: _____ TEL. #_____ FAX #_____

DX (Diagnose) if known: _____

_____

| # | Medication Name | Dose | Route | Frequency | Ordered | D/C |
|---|---|---|---|---|---|---|
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| 15 | | | | | | |

_____ _____

Provider's Signature Date

_____

Provider's Name & Title

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MR # _____

**Patient's Name**: _____ **D.O.B**.:_____
**CVS**: RRR: _____ No Murmur: _____ Reproducible CP on Palpitation, Breaths, Arm Movement: _____
**Pulm**: CTA: _____ Normal effort: _____ Wheezes/Rhonchi/Rales: _____
**ABD**: Soft: _____ NT/ND: _____ BS: _____ No Organomegaly: _____
**Rectal**: Normal: _____ Not Done: _____
**EXT**: No E/C/C: _____ Edema: Trace/+1/2/+3 L, R: _____
**Skin**: No Rash/Lesions: _____ Erythema/Papules/Macules: _____ Berign Lesions: _____
MS/Back: Normal: _____ Scar: _____ Balance/Unsteady Gait: _____ Weak: _____
Limited ROM: _____ Rigidity/Stiffness: _____ Joint Pain: _____ Joint Swelling: _____
**Neuro**: CN II-XII Intact: _____ DTR: _____ NL Cerebellar _____
NL Motor Sensory: _____ Tremors: _____ Vertigo: _____
**Mental**: Oriented to Person, Time and Place: _____ Disoriented: _____ Forgetful: _____
**GU**: No Scrotal Mass: _____ Tenderness: _____ Inguinal LAD: _____
**Pelvic**: Normal: _____
**Breast**: No Mass: _____ Tenderness: _____ Normal Axilla: _____

Environment Assessment: Clean/Organized: _____ Cluttered: _____
Support System: Lives Alone: _____ Caregiver: _____ Social Worker: _____
Assistive Device: Cane: _____ Wheelchair: _____ Walker: _____

**ASSESSMENT/DIAGNOSIS**:

**ORDER(s)**:

Plan: _____ Send to ER _____ HHA Refferal (Agency: _____)
_____ Diet/Exercise _____ Other(s) _____

_____ _____
Provider's Signature Date

_____
Printed Name Provider