

HOME MEDICATIONS [HOMEMED]
 (Include over the counter, herbal, vitamin or other alternative therapies)

Drug Allergy: _____

Admission Date/Time: _____

Nurse Historian Signature _____

Admitting Diagnosis: : _____

No Home Meds

PHYSICIAN: Following is a list of home medications as obtained by patient/family.
 Please review and indicate what medications you would like continued in the hospital:

DRUG NAME	STRENGTH	ROUTE OF ADMIN.	DOSE	FREQUENCY	LAST DOSE TAKEN	YES CONTINUE WHILE PATIENT IN THE HOSPITAL	NO, BUT CONSIDER AT DISCHARGE
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

Source of home med list (ie.,prescription bottle, written list, patient, family member, etc) _____

Date Here: _____

PHYSICIAN SIGNATURE _____

USE BALL POINT PEN ONLY

Very Good things are happening here
 Southern Ohio Medical Center



DOB: _____