STRONG HEALTH

HIGHLAND HOSPITAL

PATIENT HOME MEDICATION LIST

HH 10867F MR

☐ Inpatient
☐ Outpatient
☐ ED

Patient Name: ______________________

Bring this form with you to the hospital – DO NOT MAIL

Allergies: Drug/Foods (eggs/nuts)	List Reactions/ Side Effects	Other Allergies	List Reactions/ Side Effects
☐ None		Latex/Rubber Products (banana, kiwi, avocado, chestnut) ☐ None	
		Iodine (Contrast dye, Shellfish) ☐ None	
Date of Pneumovax vaccine ______ Date of Influenza vaccine ______		Seasonal/ Environmental/Animal ☐ None	

If any allergies, apply red allergy bracelet *For latex allergy, refer to algorithm on back*

☐ Patient is Breastfeeding
☐ Patient is Pregnant

☐ Taking no medications at home
☐ Unable to obtain medication history
Reason: ______________________

☐ Facility/patient list attached
Pharmacy used: ______________________
Phone number: ______________________

Height: ______ ft/inches ______ cm
Weight: ______ lbs ______ kg

Information Source: ☐ Patient ☐ Spouse ☐ Wallet Card
☐ Brought medications from home
☐ Other (Specify): ______________________

Information verified with prescriptions? ☐ Yes ☐ No
Medications sent: ☐ home ☐ to pharmacy ☐ not present

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (Including Prescriptions, Over-The-Counter, Herbals, Patches, Inhalers, Eye Drops, Supplements, Vitamins, Aspirin and Oxygen)

Drug Name	Dose	Frequency (how often)	Last Taken Date/Time *COMPLETED BY NURSE*	DISCHARGE (Outpatient Only) Completed by Provider Date/Time: ______
				C DC N R ______
				C DC N R ______
				C DC N R ______
				C DC N R ______
				C DC N R ______
				C DC N R ______
				C DC N R ______
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				C DC N R ______
				C DC N R ______
				C DC N R ______
				C DC N R ______

[OUTPATIENT ONLY]

Key: C=continue DC=discontinue N=new R=resume on this date

Person(s) Completing Medication History:

☐ **Patient** **Date/Time:** ______ ☐ **Sent to Pharmacy**

☐ **Other** ______________________ **Date/Time:** ______

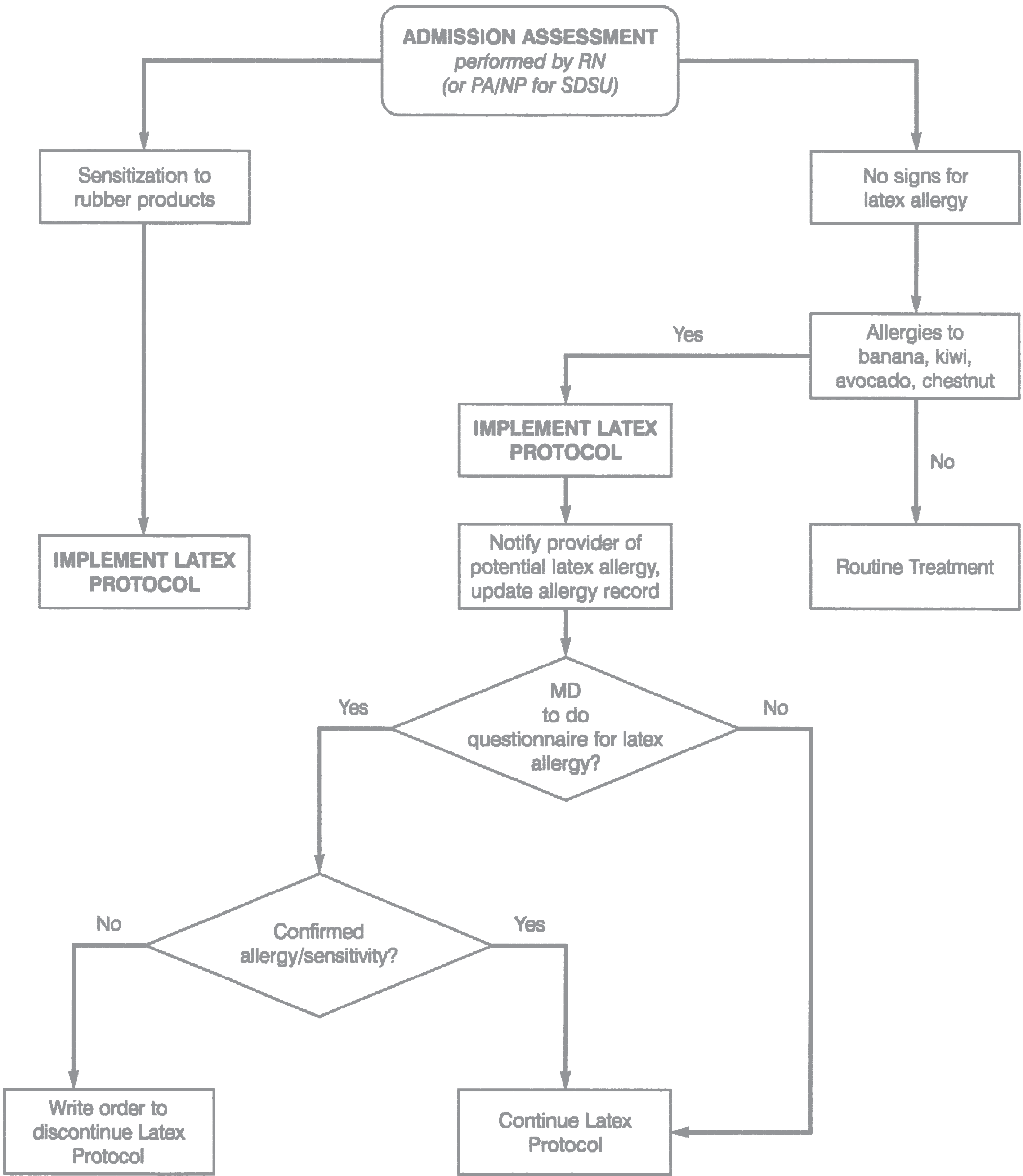
☐ **Hospital Staff** ______ **Date/Time:** ______ ☐ **Hospital Staff** ______ **Date/Time:** ______

☐ **Hospital Staff** ______ **Date/Time:** ______ ☐ **Hospital Staff** ______ **Date/Time:** ______

Outpatient Discharge Provider Signature: ______________________ Date: ______

The provider has relied upon the patient or their surrogate for the accuracy of the above list of current medications. The provider is not responsible for any inaccuracies in the list. Contact your primary care provider if you have any questions about continuing or resuming any of your medications.

PLEASE TAKE A COPY OF THIS FORM TO YOUR NEXT VISIT WITH YOUR PRIMARY CARE PHYSICIAN



ADMISSION ASSESSMENT
performed by RN
(or PA/NP for SDSU)
Sensitization to rubber products
IMPLEMENT LATEX PROTOCOL
No signs for latex allergy
Allergies to banana, kiwi, avocado, chestnut
Yes
No
IMPLEMENT LATEX PROTOCOL
Routine Treatment
Notify provider of potential latex allergy, update allergy record
MD to do questionnaire for latex allergy?
Yes
No
Confirmed allergy/sensitivity?
No
Yes
Write order to discontinue Latex Protocol
Continue Latex Protocol

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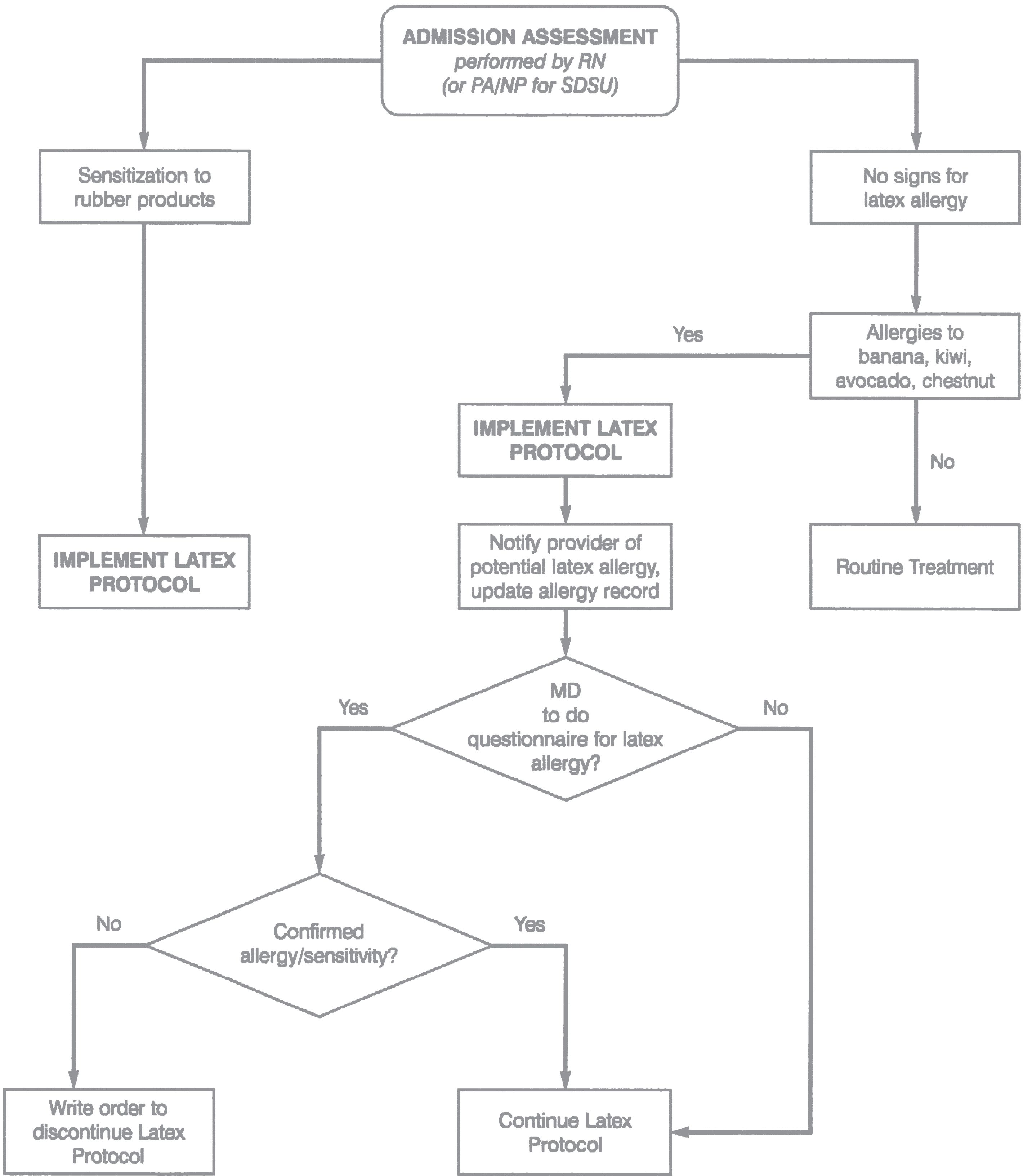
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