MEDICATION RECONCILIATION FORM
RADIATION ONCOLOGY

NAME:

MR:

- ❑ **NKA**
- ❑ **Medication Allergies:** ____

Vaccine History: check (√)all vaccines received and dates (if known):

□ Pneumonia________ □ Influenza_________ □ Tetanus________ ___□ Hepatitis____________ Mantoux/PPD__________

Date	**MEDICATION NAME** (Include over the counter and herbals)	Dose	Route	Frequency	**Continue**	**Hold/ Change**	**Check w/ Prescribing MD**
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑

I CONFIRM THAT THE MEDICATIONS LISTED ARE UP TO DATE/ACCURATE AND ARE NOT CONTRAINDICATIED IN RADIATION THERAPY.

DATE: ______________ **PATIENT/DESIGNEE SIGNATURE:** ____

MEDICATIONS PRESCRIBED WHILE ON RADIATION THERAPY- *Nursing Only Below*

Date	Medication	Dose	Route	Frequency	**Reason for Use**

Date	Medication List Verified & Updated By:	Date	Medication List Verified & Updated By:

I have received my post-radiation medication instructions. Please keep this medication Record in your wallet for your physician's office and/or upon admission to the hospital.

Date: _____________ **Patient/Designee signature:** ___________________________________