Patient Label

MEDICATION LIST

Pharmacy: _____Phone:_____Fax:_____

Allergies/Adverse Reactions/Sensitivities

Date	Time	Name of Allergies (Medication, Food, etc.)	Type of Reaction (Describe – e.g. itching etc.)	Initials

DIRECTIONS: Enter date discontinued when applicable and rewrite new or changed medications on a new line. Provide initial copy to patient upon admission, with any changes and/or when patient is admitted to another organization that requires ongoing care. Upon discharge, provide copy to the patient along with education on the importance of sharing medication information with other care provider(s).

List all Over-the-counter medications (Includes vitamins/ minerals, herbal/natural products and recreational)

Date	Time	Medication	Dose	Frequency	Route	Purpose	Initials	Date Discontinued	Initials

List all medications that patient reported as prescribed for them

Date	Time	Medication	Dose	Frequency	Route	Purpose	Initials	Date Discontinued	Initials

List all medications prescribed by Wound Care Center Provider(s)

Date	Time	Medication	Dose	Frequency	Route	Purpose	Initials	Date Discontinued	Initials

Clinician Signature: _____Date: _____Time:_____Initials:_____

Clinician Signature: _____Date: _____Time:_____Initials:_____

Clinician Signature: _____Date: _____Time:_____Initials:_____

Clinician Signature: _____Date: _____Time:_____Initials:_____