



Medication Reconciliation/BPMH* for:

Jane Doe

Two Week Period From:

02-14-2021

Social Security Number

123-45-6789

To:

02-28-2021

DOB

03-22-1985

K00

PLEASE NOTE: completed calendars
MUST be returned to SHC as part of the
patient's Medical Record

Information: 0-123-456-789

Emergency: 0-123-456-789

Website: www.samplehealthcare.com



Date (mm/dd/yyyy)

Prepared by (Signature/Printed Name)

Verified by PhC (Signature/Printed Name)

Date (mm/dd/yyyy)

Verified by RN (Signature/Printed Name)**

Counselled by (Signature/Printed Name)

Date (mm/dd/yyyy)

Parent/Legal Guardian (Signature/Printed Name)

* Best Possible Medication History

** Verification of steroids medication that are part of the patients therapy treatment

| Drug & Usage | Time | Su | Mo | Tu | We | Th | Fr | Sa | Su | Mo | Tu | We | Th | Fr | Sa |
|---|---------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| Zerit (Stavudine), 15mg Capsule(s) 4 tablets/day for 4 week(s) | 8 AM | | | | | | | | | | | | | | |
| | 12 PM | | | | | | | | | | | | | | |
| | 5 PM | | | | | | | | | | | | | | |
| | 9 PM | | | | | | | | | | | | | | |
| Valcyte (Valgancyclovir Hydrochloride), 450 mg Tablet(s) 2 tablets/day for 2 week(s) | Noon | | | | | | | | | | | | | | |
| | Bedtime | | | | | | | | | | | | | | |
| Prednisone 4 tablets/day for 4 week(s) | 10 AM | | | | | | | | | | | | | | |
| Aspirin 375 mg film coated Tablet(s) 4 tablets/day for 1 week | 8 AM | | | | | | | | | | | | | | |
| | 12 PM | | | | | | | | | | | | | | |
| | 4 PM | | | | | | | | | | | | | | |
| | 8 PM | | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | |
|---|-----------|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Salbutamol Aerosol, spray 90 mg Inhalation 6 times/day for 2 week(s) | 10 AM | | | | | | | | | | | | | |
| | 12 PM | | | | | | | | | | | | | |
| | 2 PM | | | | | | | | | | | | | |
| | 4 PM | | | | | | | | | | | | | |
| | 6 PM | | | | | | | | | | | | | |
| | 8 PM | | | | | | | | | | | | | |
| Vitamin D3 (Cholecalciferol), 1.25 mg Capsule(s) 3 capsules/day for 2 week(s) | Morning | | | | | | | | | | | | | |
| | Afternoon | | | | | | | | | | | | | |
| | Evening | | | | | | | | | | | | | |
| Ibuprofen 1 tablet/day for 3 week(s) | 6 PM | | | | | | | | | | | | | |

Mark each box with a checkmark after you have taken a dose of medicine. If you skipped a dose, please consult your physician or pharmacist. Do not take medicine on the days and times not clearly indicated on this schedule.

☒ Take a medication

☐ Skip this day