



Medication Reconciliation/BPMH\* for: Social Security Number  
**John Smith** 123-45-6789 DOB  
Two Week Period From: To:  
**02/14/2021** **02/28/2021**

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)\*\* Counselling by (Signature/Printed Name)

Date (mm/dd/yyyy) Parent/Legal Guardian (Signature/Printed Name)

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



\* Best Possible Medication History

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

Drug & Dosage	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 Hidrochloride), 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