



Medication Reconciliation/BPMH\* for: Social Security Number  
**John Smith** 123-45-6789 DOB  
03/22/1985  
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)\*\* Counseled 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



(01)01234567890123

\* 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®<br>(Stavudine), 15mg Capsule(s)<br>4 tablets/day for 4 week(s)                       | 8 AM    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|   | 12 PM   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|   | 5 PM    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|   | 9 PM    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Valcyte®<br>(Valgancyclovir Hydrochloride), 450 mg Tablet(s)<br>2 tablets/day for 2 week(s) | Noon    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Prednisone<br>4 tablets/day for 4 week(s)   | Bedtime |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Aspirin<br>375 mg film coated Tablet(s)<br>4 tablets/day for 1 week                         | 10 AM   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|   | 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