



Medication Reconciliation/BPMH* for:

Social Security Number

DOB

John Smith

123-45-6789

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)**

Counselled 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

Emergenc: 0-123-456-789

Website: www.sampleheal
thcare.com

(01)01234567890123



* 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

8 AM

(Stavudine), 15mg Capsule(s) 4 tablets/day
for 4 week(s)

12 PM

5 PM

9 PM

Valcyte

Noon

(Valgancyclovir Hydrochloride), 450 mg
Tablet(s) 2 tablets/day for 2 week(s)

Bedtime

Prednisone

10 AM

4 tablets/day for 4 week(s)

Aspirin

8 AM

375 mg film coated Tablet(s) 4 tablets/day
for 1 week

12 PM

	4 PM														
	8 PM														
Salbutamol Aerosol, spray 90 mg Inhalation 6 times/day for 2 week(s)	8 AM														
	12 PM														
	3 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