niagarahealth

Extraordinary Caring. Every Person. Every Time.

Best Possible Medication History (BPMH), Reconciliation & Prescriber Order Form

ALLERGIES (describe reaction):

INTOLERANCES (describe reaction):

Best Possible Medication History

PHYSICIAN / PRESCRIBER To Complete

Medication Name Include Prescription and regularly taken OTC, PRN, vitamin, herbal	Dose	Route	Frequency	Continue	Discontinue	Hold	Change	Reason for Change/Hold/Discontinuation	MAR
				◯	◯	◯	◯		☐
				◯	◯	◯	◯		☐
				◯	◯	◯	◯		☐
				◯	◯	◯	◯		☐
				◯	◯	◯	◯		☐
				◯	◯	◯	◯		☐
				◯	◯	◯	◯		☐
				◯	◯	◯	◯		☐
				◯	◯	◯	◯		☐
				◯	◯	◯	◯		☐
				◯	◯	◯	◯		☐
				◯	◯	◯	◯		☐

Comments/Notes:

☐ Patient reports taking medication(s) available without a prescription − unable to be verified with a second source of information. Ask patient to bring into hospital for verification.

Source of Information: (at least two, one which includes the patient/caregiver)

- ☐ Patient/caregiver recall
- ☐ Discharge summary
- ☐ ClinicalConnect
- ☐ Medication list
- ☐ Medication vial(s)/blister pack
- ☐ MAR from another facility
- ☐ Family physician list
- ☐ Community pharmacy

Patient's Community Pharmacy:

Name: _____

Phone: _____

Completed by (print): _____

Signature: _____

Date: _____ *(ddmmyyyy)* **Time**: _____ *(hhmm)*

Physician Name (print): _____

Signature: _____

Date: _____ *(ddmmyyyy)* **Time**: _____ *(hhmm)*

If additional forms are required, please fill in, page _____ of _____.

☐ **See BPMH Clarification Order Form**

Clarification #1 Date: _____ *(ddmmyyyy)* Time: _____ *(hhmm)*

Clarification #2 Date: _____ *(ddmmyyyy)* Time: _____ *(hhmm)*

☐ **BPMH reviewed on day of surgery**

Signature: _____

Date: _____ *(ddmmyyyy)* Time: _____ *(hhmm)*

0RD37

Chart Copy − Do Not Destroy − Place in Physician Order Section

−DO NOT THIN FROM CHART−

Scanned to Pharmacy: Yes ☐ or No ☐ Date Scanned: _____ *(ddmmyyyy)*

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