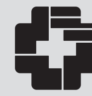
Salem Health Rehabilitation Center


Salem Health® Hospitals & Clinics

Medication List **MRN:** ____________________

PLEASE USE THIS SHEET FOR ANY MEDICATION YOU ARE CURRENTLY TAKING INCLUDING OVER THE COUNTER MEDICATIONS AND HERBAL PREPARATIONS.

PATIENT INFORMATION

☐ See Attached List

Date: ____________ **Name:** ______________________________ **Date of Birth:** ____________

MEDICATION NAME	DOSE (AMOUNT TAKEN)	FREQUENCY (HOW OFTEN)	REASON FOR TAKING

OUTPATIENT PROGRAM SUMMARY CHANGES:

(MEDICATIONS, ALLERGIES, OR SIGNIFICANT MEDICAL CONDITIONS,SURGICAL, INVASIVE PROCEDURES)

DATE/TIME	PLEASE SEE BELOW FOR ANY CHANGES	SIGNATURE