

Imaging Services Home Medication Evaluation Form

List all Medication or Contrast along with Strength and Dose to be given in Imaging:

Ordering MD:

Test Ordered:

Diagnosis:

Technologist:

Allergies:

Lab Values:

Radiologist:

Safety Precautions:

Dear Physicians: To reduce medication errors and promote patient safety, any issues between home medications and treatment medications need to be addressed. To assist you, the staff will be completing this form which lists the medications the patient (or family member) states are being taken at home. Please review PRIOR to administration of any preparatory or procedural medications and make the appropriate recommendation as to whether to proceed. Upon discharge, the patient will be given a copy for their next provider of care. Once again, please review the list and ensure that you have evaluated all home medications as appropriate. Thank you very much for your assistance.

Information From:

- Medication List Provided by Patient/Other _____ Actual medications/bottles brought in.
 Verbal report from Patient/Other _____ Nursing Home list/MAR
 Patient/Other denies any home medications to include OTC, vitamins, herbal medications & supplements

Home Medication

Reconciliation

(Prescriptions, Over the Counter, Herbals, Eye Drops, Supplements)

Item Name, Dose, Route, Frequency (Use an additional sheet if necessary)	Date/Time Last Dose Taken

Note to ordering physician:

Parenteral **radiographic contrast administration** may cause acute renal failure and has been associated with lactic acidosis in patients on metformin. Patients undergoing studies using iodinated radiographic contrast media should have **metformin** or drug combinations containing **metformin** (Glucophage, Glucophage XR, Glucovance, Riomet, Fortamet, Metaglip, Actoplus met, Avandamet) temporarily withheld just prior to and 48 hours after the completion of the procedure.

Reinstitute therapy only after normal renal function has been confirmed

On Admission:

Date/Time & Signature of Healthcare Provider completing Form

Reconciliation performed, may proceed with TEST:

Date/Time & Physician or Pharmacist Signature

DO NOT PROCEED with test at this time, will discuss with Primary Care Physician.

Date/Time & Physician or Pharmacist Signature

On Discharge:

Follow up with your Primary Care Physician regarding your home medications.

Be sure to take this Medication List with you to your next doctor visit

* Call Pharmacy at ext. 1043 for any questions - This document is part of the permanent medical record*
Place form in Physician's Order section of the chart.



500 West Main
Lewisville, Texas 75057-3699

**HOME MEDICATION EVALUATION
FORM**



PATIENT IDENTIFICATION