**Heights Medical**
**288 Boulevard**
**Hasbrouck Heights, NJ 07604**
**Phone: 201-288-6781**
**Fax: 201-288-2734**
**www.heightsmedical.com**

Heights Medical is participating in a **Medication Reconciliation Project**. We need **YOUR** support and participation to reconcile medications to ensure medications are not omitted, duplicated, have interactions, or have name/dose/route confusion.

## Help Us Reduce Medication Errors

**Please write down all of the medicines that you take.** **(Prescription and Over the Counter)**

**Your Name**:_____ **Birth date**:_____
**Your Primary Doctor**: _____ **Doctor Phone Number**:_____
**Name of your Pharmacy**:_____ **Pharmacy Phone Number**:_____

**Allergies:** ☐ None **I am allergic to latex**: ☐ Yes ☐ No

| **I am allergic to these medicines:** **(Example: Penicillin)** | **Describe Reaction:** **(Example: itch, rash)** |
|---|---|
| _____ | _____ |
| _____ | _____ |

### I take these Medicines at Home:

| Name of Medication and Dose: | How Much: | How Often: | Reason for Taking: |
|---|---|---|---|
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