Santa Clara Family Health Plan™

Medication Reconciliation Post-Discharge (MRP) Form

A completed copy of this form should be kept in the Member's Record.

Patient Information		
MEMBER NAME	DATE OF BIRTH	MEMBER ID #
PRIMARY CARE PHYSICIAN	VISIT TYPE ☐ Post-Discharge Hospital Follow Up	
MEDICATION RECONCILITATION DATE	RECONCILIATION PERFORMED DURING (select only one): ☐ Office Visit ☐ Telehealth Visit	

Discharge Information		
DISCHARGE DATE	ADMISSION DX	DISCHARGE DX
FACILITY	HOSPITALIST	

Check C for Continue or DC for Discontinue		*Medications Prior to Admission-List all Medication prescribed to Patient prior to admission below*		
C	*DC*	*Drug Name and Dose*	*Route*	*Frequency*
☐	☐			
☐	☐			
☐	☐			
☐	☐			
☐	☐			

IF THE ABOVE SECTION IS NOT COMPLETED SELECT BELOW:

☐ Patient was not prescribed any medication prior to discharge.

☐ Patient's pre-admission medication list is attached with documentation to continue or discontinue medication.

Discharge Medications-List all Medication prescribed to Patient upon Discharge below		
Drug Name and Dose	Route	Frequency

IF THE ABOVE SECTION IS NOT COMPLETED SELECT BELOW:

☐ Patient was not prescribed any medication upon discharge.

☐ Patient's discharge medication list is attached.

Provider Attestation	
I have reviewed the Patient's discharge medications and reconciled against their pre-admission medications.	
PROVIDER NAME, TITLE	PROVIDER SIGNATURE