PPets PharmProfessionals Education & Training

Medicines reconciliation checklist

A practical step-through for admission, transfer and discharge. Use alongside your local trust SOP.

Patient

Patient name: _____ DOB: ____/____/____

NHS number: _____ MRN: _____

Allergies / ADRs: _____

Reason for admission / transfer: _____

Step 1: Confirm sources (use at least two)

[ ] Patient / family interview

[ ] Patient's own medication (POD)

[ ] Repeat prescription slip

[ ] Specialist clinic letters

[ ] GP-held record (SCR / EMIS / SystmOne)

[ ] Most recent discharge letter / TTO

[ ] Community pharmacy record (eMAR / dispensing log)

[ ] Care-home MAR chart

Step 2: Document each medication

For every regular and PRN item, record: name, dose, route, frequency, indication, duration, last taken, source.

Medication	Dose & route	Frequency	Indication	Source	Discrepancy?

Step 3: Don't forget non-prescribed items

[ ] OTC analgesia, antihistamines, PPIs
[ ] Herbal supplements (St John's wort, ginseng, kava)
[ ] Vitamins & minerals
[ ] Recreational drugs / alcohol / smoking
[ ] Contraception / HRT
[ ] Eye drops, inhalers, topical preparations

Step 4: Resolve discrepancies

[ ] Intentional change (e.g. dose titrated, item stopped)
[ ] Unintentional omission - escalate to prescriber
[ ] Dose / frequency error - escalate to prescriber
[ ] Duplicate therapy - flag for review
[ ] New interaction risk - flag for review
[ ] Adherence concern - document and refer to clinical pharmacist

Step 5: Document

[ ] Reconciliation recorded in EPMA / paper drug chart
[ ] Discrepancies flagged in clinical notes
[ ] Pharmacist / prescriber notified of unresolved issues
[ ] Discharge or transfer letter reflects final list
[ ] Patient / carer informed of any changes

Completed by: _____ Role: _____ Date: ____/____/____
Time: _____

Practise medicines reconciliation with realistic scenarios in the Medicines Reconciliation Trainer - launching at **ppets.co.uk**