## DE NOVO TREATMENT CENTRE - MEDICATION RECONCILLIATION

Please complete this form and return to De Novo Treatment Centre (Fax: 705-788-2607) (Email: <a href="mailto:Admissions@denovo.ca">Admissions@denovo.ca</a>) (Phone: 1-800-933-6686 or 705-787-0247)

Client Name:		DOB:	
Address:		Phone:	
Please complete either BOX A <u>or</u> BOX B but not both.			
BOX A  ☐ I am NOT prescribed any medic arriving with any medication or s		over-the-counter medicati	on or supplement. I will not be
Client Signature		Date	<del></del>
BOX B – Complete this section  I AM PRESCRIBED medications summary of my prescribed med qualified health care provider who I am taking OVER THE COUNT health care provider considers to I am on a SMOKING CESSATION	s and/or supplements by my qualications (below) or attached a sino is prescribing the medication ER (OTC) MEDICATIONS OR shem safe and appropriate for m	alified health care provide ummary of my medications. S. SUPPLEMENTS NOT PReto take while in resident	RESCRIBED, and my qualified iteratment.
Client Signature		Date	
Medication/Product Name	Reason for Taking	Dosage - Time	Prescribed or OTC
Prescriber / Pharmacist Contact Information:			Stamp
Name:		—	
Phone:			
Signature:		Date:	

## MEDICATION RECONCILIATION ADDITIONAL COMMENTS OR INFORMATION