DE NOVO TREATMENT CENTRE – MEDICATION RECONCILIATION

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

Client Name: _____ DOB: _____

Address: _____ Phone: _____

- **Please list ALL known medication allergies or contraindications on the back side of this page.**
- **Please complete either BOX A or BOX B but NOT BOTH.**

BOX A

☐ I am NOT prescribed any medication or self-administering any over-the-counter medication or supplement. I will not be arriving with any medication or supplement.

_____

Client Signature Date

BOX B – Complete this section with your prescriber or pharmacist.

☐ I AM PRESCRIBED medications and/or supplements by my qualified health care provider. I have documented a summary of my prescribed medications (below) or attached a summary of my medications from my pharmacy or the qualified health care provider who is prescribing the medications.

☐ I am taking OVER THE COUNTER (OTC) MEDICATIONS OR SUPPLEMENTS NOT PRESCRIBED, and my qualified health care provider considers them safe and appropriate for me to take while in residential treatment.

☐ I am on a SMOKING CESSATION PLAN supported by my qualified health care provider.

_____

Client Signature Date

Medication/Product Name	Reason for Taking	Dosage - Time	Prescribed or OTC

Prescriber / Pharmacist Contact Information:

Name: _____

Address: _____

Phone: _____ Fax: _____

Stamp

Signature: Date:

MEDICATION RECONCILIATION
ADDITIONAL COMMENTS OR INFORMATION