DE NOVO TREATMENT CENTRE – MEDICATION RECONCILIATION

BOTH SIDE OF THIS PAGE MUST BE COMPLETED BY YOUR PRESCRIBER OR PRIMARY PHARMACIST

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: _____

MANDATORY PRESCRIBER or PHARMACY **Initial each medication if there are medical reason that would prohibit the use of**

_____ Tylenol **_____ Ibuprofen** **_____ Naproxen**

CURRENT MEDICATIONS PRESCRIBED BY QUALIFIED HEALTH CARE PROVIDER

Prescribed Medication	Reason for Taking	Dosage - Time

MEDICATION ALLERGIES OR CONTRAINDICATIONS AND SYMPTOMS

☐ **No known medication allergies or contraindications**

☐ **Yes. Please describe.**

OVER-THE-COUNTER MEDICATIONS/SUPPLEMENTS APPROVED FOR USE
CHECK ONLY THOSE THAT APPLY

Pain & Fever
☐ Acetaminophen (Tylenol)
☐ Ibuprofen (Advil, Motrin)
☐ Naproxen (Aleve)
☐ Aspirin
☐ Muscle/Joint Pain Rubs (Voltaren, A535)
☐ Other:

Gastrointestinal
☐ Antacids (Tums, Rolaids)
☐ Acid Reducers
☐ Anti-Diarrheal (Imodium)
☐ Laxatives (RestoraLAX, Senokot)
☐ Stool Softener
☐ Anti-Gas (Ovol/Gas-X)
☐ Gravol
☐ Pepto-Bismol
☐ Probiotics
☐ Other:

Vitamins & Mineral Supplements
☐ Multivitamin
☐ Vitamin C
☐ Vitamin D
☐ Vitamin B12
☐ Calcium
☐ Iron
☐ Magnesium
☐ Zinc
☐ Fish Oil/Omega-3
☐ Probiotics
☐ Protein Powder
☐ Creatine
☐ Herbal Supplements Specifically:
☐ Other:

Nicotine Replacement Therapies
☐ Nicotine Patch
☐ Nicotine Gum
☐ Nicotine Lozenges
☐ Nicotine Inhaler
☐ Other:

Allergies
☐ Cetirizine (Reactine)
☐ Loratadine (Claritin)
☐ Fexofenadine (Allegra)
☐ Diphenhydramine (Benadryl)
☐ Allergy Eye Drops
☐ Nasal Allergy Spray
☐ Other:

Ointments & Creams
☐ Polysporin
☐ Hydrocortisone Cream
☐ Antifungal Cream
☐ Calamine Lotion
☐ Antihistamine Cream
☐ Other:

Sleep Aids
☐ Melatonin
☐ Diphenhydramine (Benadryl Sleep Aid)
☐ Magnesium (for sleep)
☐ Herbal Sleep Aids (Valerian, Chamomile, etc.)
☐ Other:

Cold / Flu / Sinus
☐ DayQuil / NyQuil
☐ Decongestant (Sudafed)
☐ Cough Syrup
☐ Cough Lozenges
☐ Saline Nasal Spray
☐ Sinus Rinse
☐ Other:

Prescriber / Pharmacist Contact Information (Must Complete)

These medications/supplements are considered safe and appropriate for the client.

Name: _____

Address: _____

Phone: _____ Fax: _____

Signature: _____ Initials:_____

Date: _____

Stamp