Wayne Memorial Hospital – Imaging Department

Medication Reconciliation

Medication information obtained from: ☐ Patient ☐ Family ☐ Other: _____

Allergies: _____

☐ No Known Allergies

Name of Medications ☐ None

1	11
2	12
3	13
4	14
5	15
6	16
7	17
8	18
9	19
10	20

Current Metformin Products*

Actosplus Met	Metformin
Actosplus Met XR	Metaglip
Avandamet	Glumetza
Fortamet	Prandimet
Glucophage	RioMet
Glucovance	Kombiglyze XR
Janumet	

*See reverse for discharge instructions for patients taking Metformin products.

Signature of Technologist / Nurse obtaining / verifying history: _____

Patient Label

Discharge Instructions

To Be Filled Out By Staff

Metformin Protocol: (for patients on metformin ONLY)

Refer to Metformin Medication List.

Do not take your Metformin product (_____) for the next 2 days. (48 hours)

Contact your Primary Care Physician if you have any questions.

Procedure: _____ Department: _____
_____ ml of _____ (contrast) administered at: _____ (time) on _____ (date)

☐ Copy given to patient at discharge ☐ Copy faxed to Primary Care Physician _____

I have received and understand the Discharge Instructions as indicated above.

Patient Signature: _____ Date: _____

Patient Label