RAS Sacramento Clinic for Hematology and Medical Oncology

PATIENT MEDICATION LIST

INITIAL VISIT

Patient Name _____ Chart # _____ DOB _____

Appointment date _____ Appointment with _____

Any Known Allergies _____ Diabetic ☐ Yes ☐ No

Pharmacy _____ Pharmacy Phone # (_____) _____

(If you do not know the pharmacy phone #, please give address or location.)

PRESCRIBING M.D.	MEDICATION (Dose/Frequency/Quantity)

Doctor/RN Medication Review

HO-14 (5/10)

Initials: _____ Date: _____