Medication reconciliation saves lives

1. Interview the patient ✓
   Obtain a best possible medication history (BPMH)

2. Confirm patient medication history ✓
   Use more than one source

3. Document and discuss discrepancies ✓
   Match patient’s own and prescribed medications

4. Review medication list ✓
   Check at ward transfer and discharge

5. Communicate therapy changes ✓
   Talk to patient and community clinicians at discharge

Refer to the Medication history and management plan (WA MMP) for details