# Discharge Medication Schedule as of (Date):

Include all prescription and over‐the‐counter medications, vitamins and herbal supplements.

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| --- | --- | --- | --- |
| **Medication Name** | **Reason for taking this Medication** | **Dosage and Instructions** | **Comments** |
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Page of

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| **Additional Medications as Needed** |
| **Additional Medications As Needed** |  |  |  |
| **Discontinued Medications** |
| **Do Not Take the Following** |  |  |  |
| **Avoid the following:** |
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Page of