Patients are encouraged to bring medications and alternative/herbal remedies they are currently taking to the hospital at the time of admittance to assist the physician during the history procedure. Such medications and/or supplements should preferably be removed from the hospital premises at the conclusion of the admitting history procedure or should be packaged and stored with the patient’s other belongings as per hospital policy 2.4 (Patient Valuables) and returned to the patient at the time of discharge.

If it is necessary for a patient to continue therapy on a medication that is not normally available from the pharmacy (i.e., a non-formulary drug), the patient’s own supply may be used provided the conditions below are met. Herbal remedies and alternative medications will not be allowed.

1. A physician writes an order in the patient’s chart. The order must include the name, strength, and dose to be administered. Writing “Patient may take own med” without the name, strength and dose of the medication is not considered a legitimate order.

2. The patient’s own medication is identified by a pharmacist.

   A. Since intravenous admixtures and total parenteral nutrition solutions cannot be positively identified, the patient’s supply of these medications may not be used.

   B. The patient’s home controlled substance may not be used. Exception: The pharmacy director/designee may allow use of the patient’s own medications for treating ADD/ADHD/narcolepsy when deemed appropriate.

   C. Any medication whose contents or integrity cannot be verified (e.g. opened oral liquids, ophthalmic solutions) may not be used.

   D. If the medication cannot be identified, is adulterated, or otherwise unsuitable for use, the pharmacist will notify the patient’s physician, and the patient’s own med may not be used.
3. If the prescriber indicated that a patient may use their own medication, the drug order must be entered into the pharmacy computer system patient profile so that drug interactions, incompatibilities and patient allergies can be checked.

4. The nursing staff will send the patient’s home medication, along with a consult form (S/N 1186) to the pharmacy department for identification.

5. The medication is then returned to the patient care area to be stored with other medications and administered by a nurse. The completed consult form is added to the medical record.

6. Medications administered that are brought in by the patient must be recorded on the Medication Administration Record (MAR).

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Administrator

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Date

Approved by P & T Committee 11/15/99

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Approved by Clinical Board: 5/16/00, 12/17/02
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