Why medication reconciliation matters

- Avoids missed or duplicate medications
- Prevents harmful drug interactions
- Helps your healthcare team understand exactly what you take at home, in hospital, or at appointments
- Supports your safety when

Figure 2

Saskatchewan Health Authority

Always remember to:

- Bring all of your medications or a complete medication list to the hospital or clinic.
- Share your pharmacy name, phone number and your family doctor or nurse practitioner's contact information.

P I E R **CS-PIER-0337**

- If you don't have a family physician or nurse practitioner please tell your healthcare team.
- Review your medications with your doctor, nurse, or pharmacist.
- Keep your medication list updated—write down any changes.

Medication Reconciliation Committee
MedRec@saskhealthauthority.ca

saskhealthauthority.ca

Healthy People, Healthy Saskatchewan

Saskatchewan Health Authority

Medication Reconciliation for Patients

Helping to ensure you receive the right medications while in our care

Figure 1

P I E R **CS-PIER-0337**

Area: Provincial
FEBRUARY 2026

What is medication reconciliation?

Your healthcare team carefully checks the list of medications you take at home with the medications ordered for you in the hospital. If there are any differences, they address them so you get the right medication while you are in our care.

They make sure you have the correct medication:

- while you are in hospital; and,
- when you go home.

By sharing an up-to-date list of the medications you take at home, you and your family play an important role in helping to ensure the safety of your care.

Together we can prevent medication errors.

The Saskatchewan Health Authority works in the spirit of truth and reconciliation, acknowledging Saskatchewan as the traditional territory of First Nations and Métis People.

How do I help?

Bring your medications or a list of your medications. Bring all of your medications (including pills, inhalers, eye drops, cream, vitamins or herbal products) or a complete medication list when you come to hospital.

Share important contacts. Give your healthcare team the name and phone number of your pharmacy and your family doctor or nurse practitioner's name.

Be part of the review. Work with your doctor, nurse, or pharmacy professional to go over both your old and new medications.

Keep your list up–to-date. Write down any changes you, your doctor or your nurse practitioner make to your medications and update your list regularly.

Figure 3

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When does medication reconciliation occur?

- When you first come to the hospital, some programs, or a long -term care facility
- When you are transferred from one hospital to another, or from one care area of the hospital to another
- When you go home from hospital, are no longer admitted to a program or when who leave a long-term care facility.

Ask Questions!

If a medication you receive while in in our care seems different than what you take at home, ask us about it.

You are the best person to help ensure you are receiving the correct medications.