

DO NOT DETACH

MEDICATION RECONCILIATION

Please bring this completed form with you on the day of Surgery/Procedure

Patient Name: _____

Date of Birth: _____

Date of visit: _____

Primary Care Physician (PCP): _____

Acknowledgement: I confirm that this is a complete and accurate list of my (patient's) current medication, to the best of my knowledge, including prescription and over the counter drugs. I understand that healthcare providers will make medical decisions based on this information.

Name of person completing this form if other than patient:

ALLERGIES: List all allergies to medications, herbs, food, latex, IV contrast and other.

Describe the reaction. (Example: Sulfa-rash)

NONE

CURRENT MEDICATIONS: List your prescription, herbal and over the counter medicines you take.

NONE Patient poor historian/No family present/Unable to obtain information at this time

Upon Discharge

| Medication Name | Last Dose Taken | Dosage | Frequency | Reason | Change in Regimen |
|-----------------|-----------------|--------|-----------|--------|--------------------------|
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Reviewed by pre-op: _____

Discharge

Additional prescriptions and Specific Medication Instructions

1.

2.

3.

PATIENT INSTRUCTIONS: Above is the list of medications you indicated that you are currently taking. Resume taking your current medications, noting any checked boxes which indicate a change in your current medication regimen. Remember to follow the new medication instructions as directed. Please contact the physician who prescribed your medications if you have any questions. Your signature below means you understand these instructions.

RN

Patient/Parent/Conservator/Guardian

Date

Time