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 medications, 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
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
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