MEDICATION RECONCILIATION

PATIENT NAME: _____ DOB: _____

Please complete this record. A copy will be given to you at the time of discharge from our center.
***Medications:** Please list all medications prescribed by a physician as well as any over the counter medication, supplements, and vitamins that you are taking.

Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____

Medication	Dose/Strength	Frequency	Indication	Taken today?	Initials

Comments: _____
☐ Continue your pre-op medications as ordered by the prescribing physicians. Consult the prescribing physician for any questions or concerns.

☐ If your prescribing physician instructed you to stop taking any medication prior to your procedure today, please call the prescribing physician for further instructions.

***New Prescriptions:** (To be completed at the time of discharge)

Medication	Dose/Strength	Frequency	Indication	Next Dose due

Patient Signature: _____ Date/Time: _____

Nurse Signature: _____ Date/Time: _____