

TO BE COMPLETED BY PATIENT PRIOR TO PROCEDURE

MEDICATION RECONCILIATION FORM

Allergies (Medication, Foods and Other Products):

Active Medication List: List below all medicines you are taking at the time of admission. Include all medicines, vitamins and herbal products

() Confirmed with patient in preop RN Signature: _____

Dosing Information Is Required If Possible

Medication Name	Dosage	Frequency	Last dose	Reason For Med

On No Medications ()

AT DISCHARGE

Continue at Discharge
Do Not Take upon Discharge

MD Signature

PACU RN Signature

Copy Given to Patient ()

Notes:

Information obtained by:
Patient
Bottles/List
MD Office Records

New Medicines Prescribed for Patient At Time Of Discharge