Patient Medication Reconciliation Form

If you are returning for a second surgery at this facility and there have been NO changes to your medications, you do not need to fill out this form. Please just sign and date:
Patient Signature: _____ Date: _____

*PATIENTS, PLEASE FILL OUT ONLY THE SHADED AREAS OF THIS FORM:

Name (PLEASE PRINT) _____

ALLERGIES: (including medications, food and latex)	TYPE OF REACTION NOTED

Please list all medications including prescriptions (examples: pills, inhalers, creams, shots), over the counter medications (examples: aspirin, antacids, diet pills, herbals such as ginseng, gingko), vitamins and birth control medications. Include medications taken as needed (example: nitroglycerin, inhalers).

Home Medication Name	Dose	Frequency (How often?)	Reason for Taking	Last Taken (date/time)

PLEASE NOTE: This oganization and its providers are not responsible for medications ordered by other organizations or providers. The above is a list of your medications provided to us by yourself or responsible adult.

New Prescription Added After Procedure	Dose	Frequency (How often?)	Reason for Taking

Information obtained from: □Patient □Spouse □SO Other: _____

□Patient unable to give detailed information. Reason: _____

Pre-op RN Signature: _____ Date/Time:_____
□ **Copy given to patient upon discharge by:**

Nurse Signature: _____ Date/Time:_____

PATIENT LABEL

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Patient Signature: _____ Date/Time:_____