MEDICATION RECONCILIATION/ALLERGY FORM

PATIENT NAME:_____ **DOB:**_____
PHARMACY NAME:_____ **LOCATION:**_____ **PHONE#**_____

ALLERGIES: Y N (LIST ALL MEDICATIONS/REACTIONS INCLUDING LATEX AND FOOD)

MEDICATION/REACTION	MEDICATION/REACTION

(List all medications, OTC drugs, Herbal supplements) **Write NONE if no meds are taken**

Medication (RN check if taken today)	Dose/Frequency	Unknown	Indication (Reason)
○		○	
○		○	
○		○	
○		○	
○		○	
○		○	
○		○	
○		○	
○		○	
○		○	
○		○	
○		○	
○ BLOOD THINNERS		○	
○		○	
○		○	

ATTESTATION: **The above is a complete and accurate medication list to the best of my knowledge. It includes over the counter and herbal supplements, as well as regular and occasionally used prescription drugs. Your physician is resuming the start of your medication on the information provided by you, including the name of the medications, dosages and frequency.**

Patient/Guardian Signature:_____ **Date:**_____

Medication Instructions Reviewed with Patient

Nursing Use Only: Source: ___Patient ___Family ___List
Obtained By: Pre-OP RN Signature:_____ **Date:**_____
Anesthesiologist_____ **Date:**_____
OR RN Signature:_____ **Date:**_____

You may safely resume taking all of the above medications after your procedure, including over the counter medications and dietary supplements prescribed by your physician. EXCEPTIONS SEE BELOW:

Medication Dosage/Frequency	Resume Medication Date/Time

New Medication Prescribed Following Your Procedure

Medication	Dosage/Route/Frequency	Next dose

PACU RN Signature:_____ **Physician Signature:**_____