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

Medication Name	Last Dose Taken	Dosage	Frequency	Reason	Upon Discharge 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

Hoag Orthopedic Institute

Surgery Center