FILL OUT AND RETURN THE DAY OF PROCEDURE

MEDICATION RECONCILIATION/ALLERGY FORM

PATIENT NAME:_____ **DOB:**_____
PHARMACY NAME:_____ **LOCATION:**_____ **PHONE#**_____
ALLERGIES: (SEE BELOW) MEDICATION: Y N FOOD (INCLUDING EGGS OR SOY) Y N LATEX Y N

MEDICATION or FOOD/REACTION	MEDICATION or FOOD/REACTION

(List **ALL** medications, OTC drugs, Herbal supplements) **EVEN IF YOU HAVE NOT TAKEN THEM TODAY**

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

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:**_____

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:**_____