PATIENT MEDICATION RECONCILIATION Form

Premier Outpatient Surgery Center

Name:	Date of Birth:	Age:
Allergies: ☐ Yes ☐ No known allergies	Latex Allergy ☐ No ☐ Yes ☐ Testing performed for Latex allergy	

Allergy (Drug)	Reaction	Allergy (drug)	Reaction

Current Prescriptive Medications.

Name of Medication (print please)	Dose	How Often	Continue After Discharge	Stop After Discharge

Herbals, Vitamins, Supplements, Non-Prescriptive Drugs.

Name of Medication (print please)	Dose	How Often	Continue After Discharge	Stop After Discharge

Signature of person filling out form_____**Date:**_____

New Medications or New Dosages you should take after discharge.

Name of Medication (print please)	Dose	How Often	Continue After Discharge	Stop After Discharge

Signature of Patient/Responsible Person:_____**Date:**_____

Nurse Signature:_____**Date:**_____

Physician Signature:_____**Date:**_____