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:**__________________________