Tennessee Endoscopy Center Medication/Discharge Form

MD/RN Signature:

Office Use Only (Patient Label)

Date:_

Please complete the following and bring back on your scheduled procedure date.

Failure to bring with you could delay your procedure

Source:	Reaction:	Reaction:		Source:		Reaction:	
Example: Penicillin	Hives	Hives		4.			
1.			5.	× ×			
2.			6.				
3.			7.				
MEDICATION -List the names of any medications you are taking. Please include any over the counter medicine (including vitamins, minerals, and herbal supplements). Also include any medications you held for your procedure.	STRENGTH -List the strength of each tablet, capsule, etc.	How much are you taking? (number of tablets, units capsules, etc.)	FREQUENCY -How often do you take the medication? (daily, twice a day, as needed, etc.)	ROUTE -How are you taking this medication? (by mouth, injection, patch, etc.)	LAST DOSE TAKEN -Indicate the date and time of the last dose taken	Physician Use Only. Discharge Changes (check if yeand refer t Discharge Instruction below*)	
Example: Furosemide	40mg	2 tablets	daily	by mouth	yesterday		
Example: Ibuprofen	200mg	2tablets	as needed	by mouth	last night		
Patient/Guardian Sign					Dat	e:	
Discharge Instructions: (X) The medication(s) you w () *Based on your procedure	ere taking prior to y	our procedure ha			edications:		
() NEW Medication Instructions:							
	any questions abou	ut medications NO	OT prescribed by		, please conta	ct your	