Maryland Endoscopy Center
100 West Road-Suite 115
Towson, Maryland 21204

Patient Medication Reconciliation

Name:	Date of Birth:	Age:

Allergies: Yes No known allergies

Latex Allergy No Yes Testing performed for Latex allergy

Allergy (Medicine/Food)	Reaction	Allergy (Medicine/Food)	Reaction

Current Prescriptive Medications.

Physician Use Only

Name of Medication (print please)	Dose	How Often	Last Dose Taken/Time	*Continue* After Discharge	*Stop* After Discharge

Herbals, Vitamins, Supplements, Non-Prescriptive Drugs.

Name of Medication (print please)	Dose	How Often	Last Dose Taken/Time	*Continue* After Discharge	*Stop* After Discharge

Signature of person filling out form____Date:__________________________

Signature of nurse reviewing form ____ Date:__________________________

New Medications or New Dosages you should take after discharge.

Name of Medication (print please)	Dose	How Often	Special Instructions

Prescription: Written ☐ Electronic submission ☐ Phone submission ☐

NurseSignature:____Date:___________________________

Physician Signature: Date: