Carroll County Digestive Disease Center
216 B Washington Heights Medical Center, Westminster, Maryland 21157 (Telephone) 410-857-5113

Patient Medication Form

Please complete in blue or black ink. Bring this FORM, ALL INSURANCE CARDS, and REFERRAL (if needed) with you at the time of the procedure. Please do not use white-out on this form.
REMINDER: YOUR RIDE MUST REMAIN IN THE FACILITY DURING YOUR PROCEDURE

Name:	**Birth Date:**
Procedure(s) Scheduled: (Please circle)	Upper Endoscopy Colonoscopy Flex Sigmoidoscopy Other
List Allergies and Describe Reaction:	☐ **No Allergies**

List all prescription and over-the-counter (non-prescription) medication. Please include vitamins, aspirin, and herbal preparations.

Name of Medication "*Home Medication List as Provided by Patient*"	**Dose**	**How Often Taken?**	**Date Last Taken**	***PHYSICIAN USE ONLY*** **Resume upon discharge unless noted below Discontinue (D/C) Hold (H)**

New Prescriptions (Given at discharge)

Physician Signature:

If you have any questions about your home medication please contact your prescribing physician.

Office Use Only