Patient Sticker

PATIENT MEDICATION RECONCILIATION

32nd Street Surgery Center *Page ___of___*

☐ No Known Allergies	Latex Allergy ☐ No ☐ Yes

Allergy (Drug)	Reaction	Allergy (drug)	Reaction

CURRENT Prescriptive Medications

Medication as prescribed (please print) *Name, dosage, route, frequency*	Last Taken	Stop	**Medication** as prescribed (please print) *Name, dosage, route, frequency*	Last Taken	Stop

Herbals, Vitamins, Supplements, Non-Prescriptive Drugs

Medication *Name, dosage, route, frequency*	Last Taken	Stop	**Medication** *Name, dosage, route, frequency*	Last Taken	Stop

Signature of Nurse filling out form_____**Date:**_____ **Time:**_____

****RESUME TAKING ABOVE MEDICATIONS AS DIRECTED BY THE PRESCRIBING PHYSICIAN UNLESS "STOP" IS MARKED** *(in the yellow column to the right of the medication listing).*

NEW Medications or NEW Dosages you should take after discharge.

Medication (*print please*)	**Dose**	**How Often**	**Prescription Provided** *(called to Pharmacy or written out?)*

Signature of Patient/Responsible Person:_____**Date:**_____ **Original provided to patient?**_____

Discharge Nurse Signature:_____**Date:**_____ **Time:**_____

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