ALLERGIES

Medications: _____

Other: _____

Date _____

Medication Reconciliation Form

Current Medications from home – includes prescribed, over the counter or herbal medications, and supplements

Source of Information: □ Patient □ Other _____

MEDICATION NAME	DOSE	FREQUENCY/ ROUTE	LAST DOSE / TIME		MEDICATION NAME	DOSE	FREQUENCY/ ROUTE	LAST DOSE / TIME
☐ **None**	.							
Anticoagulants/Aspirin/NSAIDS □ No □ Yes □ MD notified								
					SHORT TERM MEDICATIONS (3-14 days)			

_____ _____ **U** = unknown at this time

Pre Op Call RN Signature Date/Time Admitting RN Signature/Status Date/Time

List of Medications with prolonged effect, such as steroids □ Not Applicable

MEDICATION NAME	DATE	DOSE	SITE	INTIALS	DATE	DATE	DOSE	SITE	INTIALS

_____am/pm

Initials/Signature/Status *(of person completing section)* Date /Time

Prescriptions written but not yet started □ Not Applicable

SAMPLE MEDICATIONS □ Not Applicable

MEDICATION NAME	DATE	DOSE	FREQUENCY / ROUTE		MEDICATION NAME	LOT #	DATE	DOSE	FREQUENC/ ROUTE

□ **Copy to Patient**

_____

Signature/Status *(of person completing section)* Date /Time