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| **PLEASE COMPLETE THIS FORM AND BRING TO THE SURGERY CENTER ON THE DAY OF SURGERY** |
| **LIST ALL ALLERGIES: MEDICATION, FOOD, METAL, AND/OR LATEX** |

|  |  |
| --- | --- |
| Allergy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Allergy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Allergy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Allergy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Allergy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Allergy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **LIST ALL CURRENT MEDICATIONS: prescriptions, over-the-counter, vitamins, herbals, and “as needed” medications**  Patient was not on any medication(s) to include OTC, vitamins, and herbal medications upon admission |
| **Gray shaded areas to be filled out by Surgery Center Staff** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medication Name | Dose | Frequency | Route | Last Dose |
|  |  |  | Pill Form  Eye Drops |  |
|  |  |  | Pill Form  Eye Drops |  |
|  |  |  | Pill Form  Eye Drops |  |
|  |  |  | Pill Form  Eye Drops |  |
|  |  |  | Pill Form  Eye Drops |  |
|  |  |  |  Pill Form   Eye Drops |  |
|  |  |  | Pill Form  Eye Drops |  |
|  |  |  | Pill Form   Eye Drops |  |
|  |  |  | Pill Form  Eye Drops |  |
|  |  |  | Pill Form  Eye Drops |  |
|  |  |  | Pill Form  Eye Drops |  |
|  |  |  | Pill Form   Eye Drops |  |

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| Pre-procedure medications verified by: Date: Time: |

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| --- | --- |
| Source of Information | Provided by patient/surrogate Medication bottles brought in Record from Physician or another facility  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **PRESCRIPTIONS GIVEN TO PATIENT UPON DISCHARGE** |

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| --- | --- | --- | --- |
| Medication Name | Dose | Route | Frequency |
|  |  |  |  |
|  |  |  |  |

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| A copy of this form is given to the patient upon discharge. This form is not an outpatient prescription order form. After discharge, patients are reminded to ALWAYS consult with their primary care physician for questions concerning continuation of the above medications. |

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| Post-Procedure Signature: Date: Time: |

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| **HOME MEDICATION RECONCILIATION** |