

## MEDICATION RECONCILIATION/ALLERGY FORM

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_  
 PHARMACY NAME: \_\_\_\_\_ LOCATION: \_\_\_\_\_ PHONE# \_\_\_\_\_  
 ALLERGIES: (SEE BELOW) MEDICATION: Y N FOOD (INCLUDING EGGS OR SOY) Y N LATEX Y N

MEDICATION/REACTION	MEDICATION/REACTION

(List all medications, OTC drugs, Herbal supplements) **\*\*Write NONE if no meds are taken\*\***

Medication (RN check if taken today)	Dose/Frequency	Unknown	Indication (Reason)
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	
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<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/> BLOOD THINNERS (DENIES)		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	

**ATTESTATION:** The above is a complete and accurate medication list to the best of my knowledge. It includes over the counter and herbal supplements, as well as regular and occasionally used prescription drugs. Your physician is resuming the start of your medication on the information provided by you, including the name of the medications, dosages and frequency.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Nursing Use Only:** Source: \_\_\_ Patient \_\_\_ Family \_\_\_ List

Obtained By: Pre-OP RN Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Anesthesiologist \_\_\_\_\_ Date: \_\_\_\_\_

OR RN Signature: \_\_\_\_\_ Date: \_\_\_\_\_

You may safely resume taking all of the above medications after your procedure, including over the counter medications and dietary supplements prescribed by your physician. **EXCEPTIONS SEE BELOW:**

Medication	Dosage/Frequency	Resume Medication	Date/Time

**New Medication Prescribed Following Your Procedure**

Medication	Dosage/Route/Frequency	Next dose

PACU RN Signature: \_\_\_\_\_ Physician Signature: \_\_\_\_\_