Fish Pond Surgery Center

MEDICATION RECONCILIATION FORM

Check all sources of information: ☐ Patient ☐ Significant Other ☐ Caregiver ☐ Rx Bottle ☐ Other: _____

ALLERGIES / SENSITIVITIES:

ALLERGY / INTOLERANCE	REACTION(S)	ALLERGY / INTOLERANCE	REACTION(S)	ALLERGY / INTOLERANCE	REACTION(S)
1.		4.		7.	
2.		5.		8.	
3.		6.		9.	

☐ **Initiate DVT Protocol Risk Factor Score _____**

MEDICATION(S) PRIOR TO ADMISSION

Patient should fill out the WHITE PART ONLY below. **Screened areas for OFFICE USE ONLY.**

MEDICATION NAME *Prescriptions, OTC Medications, Herbals, etc.*	DOSE	FREQUENCY	MEDICATION STOPPED PRIOR TO PROCEDURE(S)? ☐ No medications stopped			RESUME MEDICATION AFTER PROCEDURE ☐ Resume all medications today		
			Y	N	STOP DATE	Y	N	RESUME DATE

MEDICATION REVIEWED BY NURSE:		MEDICATION REVIEWED BY PHYSICIAN:
Date	**Signature**	**Signature**

DISCHARGING NURSE

Signature:

RECONCILED MEDICATION LIST RECEIVED BY:

Signature:

Please contact our office if you have questions about your medications at ***(254) 751-9836.***

Patient Label

MEDICATION DISCHARGE INSTRUCTIONS:

☐ New Prescription or ☐ Samples	Dose	Route	Frequency
		Oral Rectal Topical	Every _____ hours as needed for _____. Other: _____.
		Oral Rectal Topical	Every _____ hours as needed for _____. Other: _____.
		Oral Rectal Topical	Every _____ hours as needed for _____. Other: _____.

☐ **No aspirin, anti-inflammatory or anticoagulant medications (such as advil, ibuprofen, coumaudin, or plavix) for _____ days.**