Clinical Associates Ambulatory Surgery Center

515 Fairmount Avenue, Suite 100 Towson, MD 21286

MEDICATION RECONCILIATION FORM

Directions: Please list the medications you currently take and answer the 4 questions for each. Do not fill in the areas designated to be completed by the Registered Nurse (RN). IMPORTATNT: Please bring this completed form with you on the day of your procedure.

Medications Listed By: _____ Date_____ Time_____

(Relationship if other than patient)

Allergies & Reactions: _____

MEDICATIONS (Prescription, Over the Counter, Herbal Supplements and Vitamins)	Indication Reason for taking this medication	Dose 1 tab, 2 tabs, etc.	Route By mouth, subq, rectal	Frequency (How often do you take your medication)	Last Dose	Continue Medications at Home
Patient takes no medications ☐					To be completed by RN	
						YES NO
						YES NO
						YES NO
						YES NO
						YES NO
						YES NO
						YES NO
						YES NO
						YES NO
						YES NO
						YES NO
						YES NO
						YES NO
						YES NO
						YES NO
						YES NO
						YES NO

The section below to be completed by RN

Information obtained: ☐ *Patient/Family* ☐ *Bottles/List* ☐ *Old records* ☐ *Retail Pharmacy* ☐ *MD Office*

☐ *Medication list given to patient*
☐ *Patient advised to provide family care provider and pharmacy with updated list.*
☐ *Patient knowledgeable of medications*

Verifying RN Signature:_____ Discharge RN Signature: _____

New Medication Orders

PHYSICIAN'S ORDER SIGNATURE: _____

DATE: _____