ALLERGIES AND REACTIONS to drugs and foods:

Please write information in white box to right

Please list all medications you take on a regular basis. Include all medications that you are taking now and all medications that you were told to stop prior to surgery. *Include prescription medications from all Doctors, herbal and therapeutic agents, Over the Counter medications, Vitamins, Eye drops, Birth Control Pills, patches, etc.* Attach additional sheet if needed.

MEDICATION NAME	DOSE	ROUTE	FREQUENCY	REASON FOR TAKING MEDICATION	LAST DOSE/ DATE & TIME	NOTES	TAKE NEXT DOSE UPON DISCHARGE AT

Signature of patient or patient representative X

THE FOLLOWING ARE NEW MEDICATIONS FOR USE AFTER SURGERY

MEDICATION NAME	DOSE	ROUTE	FREQUENCY	REASON FOR TAKING MEDICATION	LAST DOSE/ DATE & TIME	NOTES	TAKE NEXT DOSE UPON DISCHARGE AT

Signature review of Medication and Allergies across the patient continuum.

Preop _____

OR _____ ❑ Reviewed Medication Reconciliation form with patient.

PACU _____ ❑ Patient verbalizes understanding of form.

Patient/Patient Representative _____ ❑ Copy to patient

PATIENT NAME _____

DATE OF BIRTH _____

SURGEON _____

DATE _____

AFFIX PATIENT ID LABEL HERE