Medication Reconciliation

(Including prescriptions, over the counter medications, herbals, vitamins/minerals and birth control pills/patches)

Allergies	Type of Reaction Noted

Medication Name	Dose*	Frequency* *(how often?)*	Last Taken (Complete the day of surgery)	Instructions

❑ Patient unable to give detailed information. Reason: _____

Obtained from: ❑ Patient ❑ Spouse ❑ SO ❑ Prior Chart ❑ Other _____

POST SURGERY

New Prescriptions	Dose	Frequency *(how often?)*	Reason for taking	Last Taken *(if applicable)*	Instructions	Next dose to be taken at *(after discharge)*
❑ None						

❑ Copy given to patient with discharge instructions

Nurse Signature: _____ Date: _____ Time: _____

patient name