NAME____ M / F AGE__________ D.O.S.______________

ALLERGIES / REACTIONS: List ALL Allergies / Sensitivities to Medications, Foods, Soaps, Dyes, and Materials.

Describe reactions: ____

____

☐ NO KNOWN drug allergy Allergic to latex? ☐ Yes ☐ No ☐ No routine medications taken

Information source: ☐ Patient ☐ Family ☐ Medication container ☐ Medical Records

****Ask your prescribing physician / surgeon when to restart Coumadin, Plavix, Aspirin, or any blood thinning medications.

***Resume your Pre-Op medications unless otherwise instructed.

List all prescription and Over-The-Counter (non-prescription) medications, including vitamins & herbal preparations:

Medication Name	Dose	Frequency	Route
		Once a day Twice a day Three times a day As needed Other______	☐ By mouth ☐ ______
		Once a day Twice a day Three times a day As needed Other______	☐ By mouth ☐ ______
		Once a day Twice a day Three times a day As needed Other______	☐ By mouth ☐ ______
		Once a day Twice a day Three times a day As needed Other______	☐ By mouth ☐ ______
		Once a day Twice a day Three times a day As needed Other______	☐ By mouth ☐ ______
		Once a day Twice a day Three times a day As needed Other______	☐ By mouth ☐ ______
		Once a day Twice a day Three times a day As needed Other______	☐ By mouth ☐ ______
		Once a day Twice a day Three times a day As needed Other______	☐ By mouth ☐ ______

Signatures:

• Pre-Op RN: ____________________ Admitting RN: ____________________ Discharge RN: ____________________

NEW PRESCRIPTIONS

(Prescribed After Surgery)

☐ Rx given Pre-Op by MD's office

Medication Name	Dose	Frequency	Route	Date to Start Prescription
			☐ **By mouth** ☐ ______	
			☐ **By mouth** ☐ ______	
			☐ **By mouth** ☐ ______	

This is not an order form. I have reviewed and reconciled these medications:

Physician's Signature ____________________________________, MD Date__________ Time__________

*Patient: Please call your prescribing physician's office if you have any questions regarding your medications.

I have received a copy of this form:

Patient's / Responsible Adult's Signature________________________________ Date__________ Time__________

Fremont Surgery Center
Patient Medication Reconciliation Form

[Patient Sticker]

FSC-80 (7/7/11)
Instituted: 12 Feb 2010

WHITE - CHART COPY YELLOW - PHYSICIAN COPY

PATIENT MEDICATION RECONCILIATION FORM (Page 2)

Medication Name	Dose	Frequency	Route
		Once a day Twice a day Three times a day As needed Other_____	☐ By mouth ☐ _____
		Once a day Twice a day Three times a day As needed Other_____	☐ By mouth ☐ _____
		Once a day Twice a day Three times a day As needed Other_____	☐ By mouth ☐ _____
		Once a day Twice a day Three times a day As needed Other_____	☐ By mouth ☐ _____
		Once a day Twice a day Three times a day As needed Other_____	☐ By mouth ☐ _____
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		Once a day Twice a day Three times a day As needed Other_____	☐ By mouth ☐ _____
		Once a day Twice a day Three times a day As needed Other_____	☐ By mouth ☐ _____
		Once a day Twice a day Three times a day As needed Other_____	☐ By mouth ☐ _____

Signatures:

• Pre-Op RN:_____ **Admitting RN:** _____ **Discharge RN:** _____

Fremont Surgery Center
Patient Medication Reconciliation Form

[Patient Sticker]

FSC-80 (4/6/10)
Instituted: 12 Feb 2010
WHITE - CHART COPY YELLOW - PATIENT COPY