Surgery Center South

Medication Reconciliation Form

ALLERGIES: ☐ **No Known Allergies**

	☐ Rash ☐ Itch ☐ Nausea/Vomiting ☐ Flushing ☐ Anaphylaxis ☐ Other:
	☐ Rash ☐ Itch ☐ Nausea/Vomiting ☐ Flushing ☐ Anaphylaxis ☐ Other:
	☐ Rash ☐ Itch ☐ Nausea/Vomiting ☐ Flushing ☐ Anaphylaxis ☐ Other:
	☐ Rash ☐ Itch ☐ Nausea/Vomiting ☐ Flushing ☐ Anaphylaxis ☐ Other:
	☐ Rash ☐ Itch ☐ Nausea/Vomiting ☐ Flushing ☐ Anaphylaxis ☐ Other:

Home Medication List: ☐ **Listed by patient** ☐ **MD office list** ☐ **List from pharmacy** ☐ **Bottles** ☐ **Other**

HOME MEDICATIONS Prescriptions, OTCs, Herbals, and Vitamin Supplements, etc.	**Dose**	**Freq**	**Last Dose**	**Take @ home After Discharge**	**DO NOT Take at home after discharge**
		☐ Daily	☐ Today	☐	☐
		☐ Daily	☐ Today	☐	☐
		☐ Daily	☐ Today	☐	☐
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		☐ Daily	☐ Today	☐	☐

MEDICATIONS LISTED BY:____ **DATE**_______________

ADDED, DELETED OR CHANGED MEDICATIONS POSTOPERATIVELY **Noted medication, dose, route, frequency**
☐ Prescription given
☐ Prescription given
☐ Prescription given
☐ NA no prescriptions given/no changes noted

RECONCILIATION PHYSICIAN SIGNATURE _________________________________ **DATE**_______________

DISCHARGE NURSING SIGNATURE ___________________________________ **DATE**_______________

C1320-MEDREC
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