JEFFERSON AMBULATORY SURGERY CENTER
PAIN MANAGEMENT RECONCILLATION MEDICATION FORM

Patient Label

Data Source: □ Patient □ Family □ MD

Please include all prescriptions, over the counter, vitamins, and herbal/natural medications taken routinely prior to admission.

Allergies: _____

Name of Medication	Dosages	Frequency and Route	Indication (Why taking meds)	Prescriber	Medication Taken Date:	Medication Taken Date:	Medication Taken Date:	Medication Taken Date:

Patient Signature: _____ Nurse Signature: _____ Date: _____

Patient Signature: _____ Nurse Signature: _____ Date: _____

Patient Signature: _____ Nurse Signature: _____ Date: _____

Patient Signature: _____ Nurse Signature: _____ Date: _____