JASC SURGERY MEDICATION RECONCILIATION FORM

Patient Name: **Allergies:**

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

Data Source: □ Patient □ Family □ Other: _____ **Patient's Pharmacy & Phone #:** _____

Medication	Dosage	Frequency (When)	Medication Taken Day of Surgery	Resume as Pre-Op √	Add to List √	Discontinue √
1)						
2)						
3)						
4)						
5)						
6)						
7)						
8)						
9)						
10)						
11)						
12)						
13)						
14)						
15)						
16)						
17)						
18)						
19)						
20)						
21)						
22)						

_____ _____

Patient Signature **Date** **Signature of RN Verifying Medication List** **Date**

PHYSICIAN TO COMPLETE THIS SECTION:

□ No change; take all medications as listed □ Add □ Change □ Discontinue

_____

Physician Signature **Date**

_____

Signature of Discharge RN **Date**