UCAS UNIVERSITY CENTER FOR AMBULATORY SURGERY

MEDICATION RECONCILIATION FORM

ALLERGIES: □ NKA

ALLERGY	REACTION	ALLERGY	REACTION
1.		4.	
2.		5.	
3.		6.	

List all prescription medication, over-the-counter medication, herbal medication & vitamins/supplements. (Use multiple pages if needed)

Home Medication List – To be filled out pre-operatively					To be completed by Physician/Nurse the day of surgery		
MEDICATION	**DOSE** (mg, mcg, units, etc.)	**FREQUENCY** (daily, twice a day, monthly, etc.)	**ROUTE** (by mouth, injection, patch)	**REASON FOR TAKING**	**WHEN WAS LAST DOSE TAKEN**	**CONTINUE AFTER DISCHARGE**	**CHECK WITH PRESCRIBING PHYSICIAN**
						□ YES □ NO	€
						□ YES □ NO	€
						□ YES □ NO	€
						□ YES □ NO	€
						□ YES □ NO	€
						□ YES □ NO	€
						□ YES □ NO	€
						□ YES □ NO	€
						□ YES □ NO	€
						□ YES □ NO	€
						□ YES □ NO	€
						□ YES □ NO	€

Patient Acknowledgement: I have provided as accurate a list as I can of my home medications. I will continue to follow the medication orders of the prescribing physician unless instructed to change. If I have questions about my home medications, I will call the doctor who prescribed them.

- This current home medication list has been reviewed with the patient pre-operatively.

Patient/Guardian Signature: _____ Staff Signature: _____ Date/Time:_____

Enter new medication or changes is regimen below:

MEDICATION	DOSE	FREQUENCY	ROUTE	REASON FOR TAKING	DATE/TIME NEXT DOSE

PACU Nurse Signature: _____ MD Signature: _____ Date/Time:_____