Surgery Center South

Medication Reconciliation Form

ID / Visit: /
,
DOB:
Phys:

DOS: 1/1/0001
Sex:

ALLERGIES: Please list below with reaction ☐ **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

Home Medication List **-** Please list all prescription drugs, OTCs, Herbals, Vitamins and Supplements

Medication	Dose	Frequency	Date:_____ **Date Last Taken**	Date:_____ **Date Last Taken**	Date:_____ **Date Last Taken**	Date:_____ **Date Last Taken**	Date:_____ **Date Last Taken**

Added, Deleted or Changed Medications Postoperatively

DOS_____	DOS_____	DOS_____	DOS_____	DOS_____
☐ Rx Given:	☐ Rx Given:	☐ Rx Given:	☐ Rx Given:	☐ Rx Given:
☐ NA no Rx Given	☐ NA no Rx Given	☐ NA no Rx Given	☐ NA no Rx Given	☐ NA no Rx Given
☐ Take All Meds @ home after discharge	☐ Take All Meds @ home after discharge	☐ Take All Meds @ home after discharge	☐ Take All Meds @ home after discharge	☐ Take All Meds @ home after discharge
☐ Take All Meds @ home after except:	☐ Take All Meds @ home after except:	☐ Take All Meds @ home after except:	☐ Take All Meds @ home after except:	☐ Take All Meds @ home after except:
PACU Nurse: _____ DOS_____	PACU Nurse: _____ DOS_____	PACU Nurse: _____ DOS_____	PACU Nurse: _____ DOS_____	PACU Nurse: _____ DOS_____