

SIMI SURGERY CENTER MEDICATION RECONCILIATION FORM

Patient Allergy Validation Sticker

NOT CURRENTLY TAKING HOME MEDICATIONS

Names of Medications	Dose (mg)	Frequency (How Often)	Route (how) (oral, inj, patch)	Indication (Why taking med?)	Last Dose taken on	To Be Completed for Discharge			
						Resume as pre-op ✓	Change To:	Add to list ✓	Discontinue ✓

PHYSICIAN TO COMPLETE THIS SECTION: POST-OP MEDICATION ORDERS:

PHYSICIAN SIGNATURE _____ **DATE** _____

Signature of RN obtaining original list _____

Signature of discharge RN _____

Note to Patient: Please take this medication list to your next doctor’s appointment. It is recommended that you bring a list of your current medications to each medical appointment.

Signature of Patient _____ Date _____