

Medication Reconciliation

		Dosage							Route is By Mouth <small>UNLESS noted SQ, SL, Inj, IV</small>	Daily	Twice Daily	3 Times Daily	4 Times Daily	As Needed	Other (describe)	Last Taken (Date/Time)	STOP	
		No Prescription Medications		See Attached List														
Pre-Operative	Prescription Medications																	
Non Prescription Drugs																		
Post OP New Medication																	Script? Y/N	

RESUME TAKING ABOVE MEDICATIONS AS DIRECTED BY THE PRESCRIBING PHYSICIANS UNLESS "STOP" IS MARKED (in the yellow column to the right of the medication listing).

Signature of Patient/Responsible Person: _____ Date: _____

Pre-Op Nurse Signature: _____ Date: _____ Time: _____

PACU Nurse Signature: _____ Date: _____ Time: _____

Original provided to patient?

Physician Signature: _____ Date: _____ Time: _____

Patient Label