

# PATIENT MEDICATION RECONCILIATION Form

AmSurg Center Non-System Policies

Name:		Date of Birth:	Age:
Allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No known allergies		Latex Allergy <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Testing performed for Latex allergy
Allergy (Drug)	Reaction	Allergy (drug)	Reaction

**Current Prescriptive Medications.**

Name of Medication (print please)	Dose	Last Dose Taken/Time	How Often	Call PCP After Discharge	Continue After Discharge	Stop After Discharge

**Herbals, Vitamins, Supplements, Non-Prescriptive Drugs.**

Name of Medication (print please)	Dose	Last Dose Taken/Time	How Often	Call PCP After Discharge	Continue After Discharge	Stop After Discharge

Signature of person filling out form \_\_\_\_\_ Date: \_\_\_\_\_

**New Medications or New Dosages you should take after discharge.**

Name of Medication (print please)	Dose	How Often

Signature of Patient/Responsible Person: \_\_\_\_\_ Date: \_\_\_\_\_

Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_