MEDICATION RECONCILIATION / PAIN

Allergies & Adverse Reactions:
_____

❑ NKA

Home Medications Include all vitamins, herbal and over-the-counter Medications	Dose	Frequency	Last dose taken	Resume
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No

Admit RN Signature _____Date_____

New Medication	Dose	Frequency	Reason

Medications have been reviewed with patient and/or caregiver. If you have questions regarding your medication(s) please contact the physician that prescribed it/them. Please take this list to your next doctor's visit.

_____
Patient/caregiver signature Date/Time

_____

Discharge RN_____ Date/Time

Physician Signature_____ Date/Time

AMBULATORY SURGERY CENTER OF STOCKTON
2398 N. California Street
Stockton, CA 95204
209-944-9100

NAME:
ACT#:
DOB: AGE: SEX:

DOS: