Select Surgical Center at Kennedy **Medication Reconciliation Form**

Patient Allergies

PATIENTS NAME: _____

Latex Allergy: ☐ Yes ☐ No

DATE OF BIRTH _____

☐ No known drug allergies Reaction: _____

ALLERGY	TYPE OF REACTION		ALLERGY	TYPE OF REACTION

Current Medications: including vitamins/supplements/herbals.

MEDICATION NAME / DOSE	LAST DOSE TAKEN	ROUTE	HOW OFTEN		MEDICATION NAME / DOSE	LAST DOSE TAKEN	ROUTE	HOW OFTEN

*** All starred medications indicate patient was instructed to take this medication the day of surgery.**

Patient's medication list attached ____

Patient's home medication list reviewed and verified by patient / guardian.

Pre-op Nurse Signature _____

ADDITIONAL MEDICATIONS TO TAKE FOLLOWING YOUR PROCEDURE:

MEDICATION NAME	DOSAGE	ROUTE	FREQUENCY AND INSTRUCTIONS	NEXT DOSE

☐ Patient instructed to continue all current medications and those prescribed by their surgeon with exceptions below.:

Exceptions: _____

Patient/Parent /Guardian / Signature: _____

PACU Nurse Signature: _____

Physician's Signature: _____

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