WEBSTER OUTPATIENT SURGERY CENTER

MEDICATION RECONCILIATION

Questionnaire filled out by: ☐ Patient ☐ Family/Friend ☐ RN

Patient Name:_____

Drug Allergies/Sensitivities ☐ **NONE**	
Allergen	**Reaction**

Pre-Admit Medications (to include herbals, etc.) ☐ **NONE**			**Discharge Orders**		
Name	**Dose/Route/Freq.**	**Last taken (date/time)**	**Cont.**	**Stop**	**Change (dose/route/freq.)**

☐ **CONTINUE ALL HOME MEDS AS PRESCRIBED**

Patient Signature: _____ **Date:** _____ **Time:** _____

PRE-OP RN Signature: _____ **Date:** _____ **Time:** _____

Medications Added on Discharge (dose and frequency) for reference only – this is **not** a prescription

PACU RN Signature: _____ **Date:** _____ **Time:** _____

Discharging Physician Signature: _____ **Date:** _____ **Time:** _____

☐ **COPY OF FORM PROVIDED TO PATIENT**

Patient Name:_____
Patient DOB:_____
Date of Service:_____
Patient Gender:_____
Physician:_____

PATIENT LABEL