West Coast Joint and Spine Center

Medication Reconciliation Form

Patient Name: _____ Date of Birth: _____

Primary Doctor's Name: _____ Phone Number: _____

Preferred Pharmacy & Location: _____

Allergies (medications, latex, etc.)

Name	Type of Reaction	Name	Type of Reaction
1.		4.	
2.		5.	
3.		6.	

- List ALL YOUR MEDICATIONS including, eye drops, over-the-counter and alternative medicines such as vitamins, herbals, and supplements.
- It is extremely important for your care and safety, that you provide complete and accurate information.
- Please write if you do not know or do not remember all of the medications that you take.

Medication List **[STAFF USE ONLY]**

Medication Name	Dose	How do you take it? (oral, topical, etc.)	How often do you take it?	Why are you taking this medication?	Last dose taken	Medication		Medication
						Added	Deleted	Check with Primary Care Provider
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

It is suggested that you provide a copy of this list to your Primary Care Provider.

Medication history recorded by: _____ Information verified by: _____
[Print name] [Pre-Op nurse's signature]

Medications Reconciled: _____ Date & Time: _____
[Pre-Op nurse's signature]

Copy of MRF Given: _____ Date & Time: _____
[Post-Op nurse's signature]

West Coast Joint and Spine Center and its providers are not responsible for medications ordered by other organizations or providers.