PATIENT MEDICATION RECONCILIATION

Name:	Date of Birth:	Age:
Allergies: □ Yes □ No known allergies	Latex Allergy □ No □ Yes □ Testing performed for Latex allergy	

Allergy (Drug)	Reaction	Allergy (drug)	Reaction

Current Prescriptive Medications. **After Discharge**

Name of Medication (print please)	Dose	How Often	Last Dose	Continue	Stop

Signature of person filling out form _____ Date: _____

Signature of Patient/Responsible Person:_____Date:_____

Anesthesia Signature _____Date:_____Time:_____

Physician Signature _____ Date: _____ Time: _____