Please write down your prescription medications on this form. Make sure you provide us with the dosage of each prescription medication as well as how often you are to take the medication and the last time you took it. Lastly, please bring this form with you on the day of your procedure. The physician will need to review all of your medications post procedure at the time of your discharge from our facility. At this time the physician will document whether or not you may continue, or discontinue your medications after your procedure.

Medication Reconciliation Record

Medication (ONE Medication Per Box)	Dose (amt)	How Often (Frequency)	Last Time Taken	Post Procedure Instructions (Physician Use Only)
				☐Continue ☐ Discontinue ☐ ________________
				☐Continue ☐ Discontinue ☐ ________________
				☐Continue ☐ Discontinue ☐ ________________
				☐Continue ☐ Discontinue ☐ ________________
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				☐Continue ☐ Discontinue ☐ ________________
				☐Continue ☐ Discontinue ☐ ________________
				☐Continue ☐ Discontinue ☐ ________________

Nurse Use Only: Do you take any aspirin or aspirin like products? (ie aspirin, advil, aleve, ibuprofen)	☐ No ☐ Yes	List Medications:	☐ No Restrictions Please Resume Use	☐ Refrain from Using for _____ Days
Please refrain from taking any NSAID products such as: Aspirin, Aleve, Naprosyn, Advil / Ibuprofin, Excedrin and Mobic			☐ No Restrictions May Use as Needed	☐ Refrain from Using for _____ Days

PreOP RN Signature_________________

Date_________________________

MD Signature_________________________

Date_________________________________

Revised 10/27/2015 mca