North Florida Surgery Center Medication Reconciliation

Patient Name: _____ DOB: _____

Allergies:					
Medication	**Dosage**	**Frequency**	**On day of Procedure**		**Continue to take after discharge or New**
Name of the Medication	**What strength is the medicine**	**How often do you take**	**Take**	**Hold**	
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					

The medication list was completed by: _____ Date**:** _____

The medication list was reconciled by: _____Date: _____

The medication list was updated by: _____ Date**:** _____

Please carry this list or your current medication list with you when you visit any other physician or health care provider. This will provide them with a list of any medications that you are on.

Patient Label