Huntington Ambulatory Surgery Center PATIENT MEDICATION RECONCILIATION FORM

Please fill in those areas with the *asterisks.

*Allergies (include drugs & materials)	*Reaction			*Allergies *Reaction (include drugs & materials)		Reaction
-						
				Bold Outlined Areas	For Offi	ce Use Only
*Current Medication History (include over-the- counter medication, such as herbal preparations)	*Dose	*Frequency How many times a day		Comments		Contact prescribing MD for further orders
New Prescriptions	Dose	Frequency		Comme	nts	
Source of Medicine List: (Check all that apply)						
Patient Medication List						
Patient / Family Recall		i I				
Pharmacy		1		Patient Label		
Primary Care Physician]				
Surgeon		<u> </u>				
Other						
This list is for the purpo the resumption of the m						esponsible for
VERIFIED				DATE		
PATIENT SIGNATURE				DATE		