Tri-State Centers for Sight Surgery Center

Medication Reconciliation Form Patient Name:_____

"Do not use abbreviations": U (Unit), IU (International Unit), Q. D./QD/q.d. (daily), Q.O.D/QOD/q.o.d. (every other day) Trailing Zero (X.O) (write X mg), Lack of leading zero (.X mg) write 0.X mg, MS/MSO4/MgSO4 (write Morphine Sulfate or Magnesium Sulfate)

No Known Allergies ☐

Allergies/ Reaction:_____

Betadine/Shellfish/Iodine	No	☐	YES	☐	(Reaction)
Tape	No	☐	YES	☐	(Reaction)
Latex Sensitivity/ Allergy	No	☐	YES	☐	(Reaction)

Pre-operative Medication: Patient to fill out **Discharge Medications: Discharge Nurse to fill out**

Routine Medications (include over the counter and herbals meds)	Dose	Frequency	Resume Yes	Resume No	Date to Resume Medication
Medication Held for Surgery:				Resume yes	Resume No	Date to Resume Meds

New Prescription Added: **Discharge nurse to fill out**

Patient/Patient Representative Signature_____ Date_____

Discharge Nurse Signature_____ Date_____