

MEDICATION RECONCILIATION



MUST BE COMPLETED FOR ALL PATIENTS BEING TREATED

NAME _____ **DATE** _____

Allergies

No Known Allergies
 Allergies/Reactions: _____

Betadine/Shellfish/Iodine YES NO Reaction

Tape YES NO Reaction

Latex Sensitivity/Allergy YES NO Reaction

Pre-Operative Medications: (patient to fill out)

Medications Held for Surgery	Dose	Frequency

New Prescription Added Discharge nurse to fill out	Dose	Frequency

Discharge Medications: (discharge nurse to fill out)

Resume "Yes"	Resume "No"	Date to Resume Meds

DO NOT USE ABBREVIATIONS

U (unit) IU (International Unit)
Q.D./QD/q.d. (daily) Q.O.D./AOD/q.o.d. (every other day)
Trailing Zero (x.0) - Xmg
Lack of Leading Zero (0.x) - write 0.x mg
MS/MSO4/MgSO4 - write Morphine Sulfate or Magnesium Sulfate

Patient/Patient Representative Signature

Date

Discharge Nurse Signature

Date

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