Rivertown Surgery Center

MEDICATION RECONCILIATION FORM

ALLERGY/INTOLERANCE Page _____ of _____

MEDICATION	REACTION	MEDICATION	REACTION	MEDICATION	REACTION
1.		**3.**		**5.**	
2.		**4.**		**6.**	

MEDICATIONS PRIOR TO ADMISSION

(List all medications, nutritionals, herbal supplements, pumps, patches or inhalers, drops, sprays, ointments used prior to this admission.)

Source: ☐ Patient ☐ Family ☐ Provided List ☐ Other _____

CONTINUE MEDICATIONS?

MEDICATION ☐√ if taken day of Surgery	DOSE	FREQUENCY (HOW 0FTEN)	DISCHARGE YES NO	RESUME (Date, Time)
☐			☐ ☐	
☐			☐ ☐	
☐			☐ ☐	
☐			☐ ☐	
☐			☐ ☐	
☐			☐ ☐	
☐			☐ ☐	
☐			☐ ☐	
☐			☐ ☐	
☐			☐ ☐	
☐			☐ ☐	
BLOOD THINNERS	---	---	----	----
☐			☐ ☐	
☐			☐ ☐	

Based on your visit to Rivertown Surgery Center, you may safely continue only the medications marked 'DISCHARGE Yes' above. If you have any questions, please contact your primary physician. **Your physician is resuming the start of your medication on the information provided by you, including the name of the medications, dosages and frequency.

Noted by:_____ RN Date:_____ _____MD

New Medication Prescribed Following Your Surgery

MEDICATION (including strength)	DOSE / ROUTE / FREQUENCY	NEXT DOSE

****Please bring this medication record with you to your physician's office.****