Medication Reconciliation Form

Allergies(Medication, Food or Latex)	Reaction

Pre-Operative Medications

Routinely Taken Medication (incl. Over-the-Counter,Vitamins,EyeDrops,&Herbals)	Dose	Frequency	Reason For Taking

Patient Signature Date Time

Patient Signature Date Time

Patient Signature Date Time

********** To Be Completed By Nursing Staff **********

Routine Medications Taken Morning of Surgery	Dose	Time	Comments

New Prescriptions Added	Dose	Frequency	Comments

Adverse Drug Reaction	Treatment