SURGCENTER OF BEL AIR, LLC

MEDICATION RECONCILIATION FORM **Date:_____**
(This is not a physician order form)

ALLERGIES/REACTIONS: _____

_____

Name of Drug	Dose	Frequency	Date Last Taken	Additional Instructions

PRESCRIPTIONS WRITTEN BY SURGEON DAY OF SURGERY

_____

_____

_____

RESUME MEDICATIONS AT DISCHARGE _____ **YES** _____**NO**

_____ _____

PHYSICIAN SIGNATURE **PATIENTS/RESPONSIBLE PERSON SIGNATURE**

_____

RN SIGNATURE