MEDICATION RECONCILIATION FORM

(Patient to complete shaded portion of form)

Allergies: ☐ NKDA ☐ Verified ☐ See attached list for extensive allergies

Medication	Reaction

Patient Label

Medication Information Obtained Form:

☐ Patient ☐ Family Member of patient ☐ Written List Provided by Patient

CURRENT HOME MEDICATION LIST
TO BE COMPLETED BY PATIENT PRE-OPERATIVELY
(Including: Prescription, Ove the Counter, Herbal Remedies, Vitamins, Dietary Supplements)

TO BE COMPLETED BY NURSE/PHYSICIAN ON DAY OF SURGERY

Medication/Dosage	Taken For	How Is It Taken (Oral, Inject, Patch, etc.)	How Often Is It Taken	Taken AM Or PM	When Last Dose Was Taken	Continue After Discharge	Check With Prescribing Physician
						☐ Yes ☐ NO	☐
						☐ Yes ☐ NO	☐
						☐ Yes ☐ NO	☐
						☐ Yes ☐ NO	☐
						☐ Yes ☐ NO	☐
						☐ Yes ☐ NO	☐
						☐ Yes ☐ NO	☐
						☐ Yes ☐ NO	☐
						☐ Yes ☐ NO	☐
						☐ Yes ☐ NO	☐
						☐ Yes ☐ NO	☐
						☐ Yes ☐ NO	☐
						☐ Yes ☐ NO	☐
						☐ Yes ☐ NO	☐
						☐ Yes ☐ NO	☐

Patient Acknowledgement:

- I have provided as accurate a list as I can of my home medications. I will continue to follow the medication orders of the prescribing physician unless instructed to change. If I have questions about my home medications, I will call the doctor who prescribed them.
- I understand that my medication list may be shared with my other physicians unless I decline. ☐ I decline.

Patient (Designee) Signature: _____ Date/Time: _____

Current home medication list has been reviewed with patient pre-operatively.

Staff Signature: _____ Date/Time: _____

NEW MEDICATIONS TO BEGIN TAKING

Medication/Dose	How Is It Taken	How Often Is It Taken	RX Given at	Med info Given
			☐ Pre-Op ☐ DOS	☐ Yes
			☐ Pre-Op ☐ DOS	☐ Yes
			☐ Pre-Op ☐ DOS	☐ Yes

Physician Signature: _____ Date/Time: _____

Staff Signature: _____ Date/Time: _____

MEDICATION RECONCILIATION

Dear Legend Surgery Center Patient:

We would like to thank you for choosing Orthopaedic Associates Surgery Center for your ambulatory surgery needs. We hope you had a comfortable stay.

Attached you will find a copy of your Medication Reconciliation Form. This form can be a useful tool for you. We suggest that you keep this form with you, in your wallet or purse. Bring it along when you see your physicians and healthcare providers. It is important to keep this form current, revising it whenever a medication is added or discontinued. You may also choose to share the form with your pharmacist.

Remember, you are the most important member of your healthcare team. The more educated you are about your own care, the better you are able to advocate for yourself.

Here are some critical things to remember as it relates to your medications:

- Know why you are taking the medication that has been prescribed.
- Make sure you understand how to take the medication as prescribed:
    - Can the medication be cut or crushed?
    - Should it be taken with meals or on an empty stomach?
    - Should you avoid alcohol while taking the medication?
    - How often should the medication be taken?
- Remind the person prescribing medications about all of the other medications you are currently taking – including over the counter medications, supplement and herbal medication.
- Remind the person prescribing medications about any allergies you may have.
- Remind the person prescribing medications about any history of adverse reactions.
- Contact your physician immediately if you have any negative side effects.
- Don't stop taking a medication without speaking to your physician first.
- Use your pharmacist as a resource, make sure you understand all instructions given concerning your medications.

Once again thank you for choosing Orthopaedic Associates Surgery Center for your ambulatory surgery needs. We hope you find this form useful.

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