ASI SURGERY CENTER INC. MEDICATION RECONCILIATION

PATIENT NAME:_____ MRN: _____ DOB: _____

Source of Medication List *(Check All That Apply)*: ☐ Patient Interview ☐ Patient's Own List ☐ Caregiver Interview ☐ Pharmacy ☐ Primary Care Provider ☐ Surgeon

☐ other, please specify: _____Preferred Pharmacy Name/Phone#/Location: _____

Allergies (include drugs and materials) and Reactions

Routinely Taken Medications (includes OTC)	Dose	Frequency	Indication	Taken as Prescribed	Start Date	Prescriber	Stop medication before procedure	Continue medication after procedure

NEW PRESCRIPTIONS ADDED POST-OPERATIVELY					
Medication	Dose	Frequency	Start Date	Prescriber	Comments

ADDITIONAL COMMENTS:_____

PATIENT SIGNATURE:_____ PROVIDER SIGNATURE:_____DATE: _____