# ASI SURGERY CENTER INC. MEDICATION RECONCILIATION

PATIENT NAME:_____ MRN: _____ DOB: _____

Source of Medication List *(Check All That Apply)*: ☐ Patient Interview ☐ Patient's List ☐Caregiver Interview ☐Other_____

| ALLERGIES AND REACTIONS |
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| Routinely Taken Medications (includes over the counter) | Dose | Frequency | Stop medication before procedure | Continue medication after procedure |
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| **NEW PRESCRIPTIONS ADDED POST-OPERATIVELY** | | | |
|---|---|---|---|
| Medication | Dose | Frequency | Comments |
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SPECIAL INSTRUCTIONS:_____

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PATIENT SIGNATURE:_____ DATE: _____

PROVIDER SIGNATURE:_____ DATE: _____