Patient Label

Medication Reconciliation Form and Physician Orders

Source of info: ❑ **Patient** ❑ **Med Bottles** ❑ **Family** ❑ **List** ❑ **Physician Office** ❑ **Pharmacy** ❑ **Other**

Allergies and Reactions:_____

List all prescription, over-the-counter, vitamins and herbal/natural medications taken routinely	Dosage	Frequency	Dc'd Prior to Surgery	Last Dose	Continue upon discharge	Discontinue	Check with PCP	Comments
❑ See Attached List								

Signature of Nurse obtaining original list: _____**Date:** _____ **Time:** _____

Physician Orders:

Discharge Medications	Dosage	Frequency	Comments

❑ **Unless otherwise indicated, please resume medications which have been prescribed to you when you return home.**

Physician Signature:_____**Date:**_____**Time:** _____

Signature of Nurse discharging patient:_____**Date:**_____**Time:** _____

Patient/Parent/Guardian Signature:_____**Date:**_____**Time:** _____

ASPEN SURGERY CENTER

PLEASE TAKE THIS LIST TO YOUR NEXT DOCTORS APPOINTMENT