



**PLEASE FILL OUT PRIOR TO
AND BRING TO APPOINTMENT**

Sticker _____

GI

Medication Reconciliation Form

List all medication that you are currently taking **PROCEDURE:** _____
 (include: Prescriptions, OTC, Herbals, Patches, Inhalers,
 Eye drops, Supplements, Vitamins, Aspirin and Oxygen) _____

Source Key:

- P – Patient; F – Family; MB – Medication Bottles
- MRF – Previous Medication Reconciliation Form
- MAR – Another Facility Medication Form

Allergies: _____

	Medication Name (Print)	Source (Use Key)	Dose	Route	Frequency - If PRN / Indication	Last Dose Date / Time	RN Initials
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							

RN Signature: _____ Initials: _____ Date: _____

PREVIOUSLY PRESCRIBED MEDICATIONS WERE REVIEWED. I AM NOT AWARE THAT NEW PRESCRIPTIONS DUPLICATE CURRENT MEDICATIONS. I AM NOT AWARE OF POTENTIAL INTERACTIONS BETWEEN CURRENT (PRE-OP) MEDICATIONS AND NEW MEDICATIONS.

PHYSICIAN SIGNATURE: _____ **DATE:** _____

Newly Identified Discharge Medications – DOS. Source Key: Rx, P.O.S. – Physician Order Sheet, DIS – Discharge Instruction Sheet

	Medication Name (Print)	Source	Dose	Route	Frequency - If PRN / Indication	Last Dose Date / Time	RN Signature / Initials
1							
2							
3							
4							

Form Faxed To: PMD Dr. _____ At Fax No. _____ Date: _____ Time: _____ By: _____