CENTER FOR AMBULATORY SURGERY
550 ORCHARD PARK RD. WEST SENECA, NY. 14224

OR

Medication Reconciliation Form

Sticker

List all medication that patient is currently taking (include: Prescriptions, OTC, Herbals, Patches, Inhalers, Eye drops, Supplements, Vitamins, Aspirin and Oxygen)

PROCEDURE: _____

Allergies:

Reconciliation Key

P - Patient; F - Family; MB - Medication Bottles
MRF - Previous Medication Reconciliation Form
MAR - Another Facility Medication Form
CL - History and Physical / Clearance
O - Other

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

❑ Yes ❑ No Do we have permission to fax your medication reconciliation form which indicates your procedure to your primary physician

RN Signature: _____ Initials: _____ Date: _____

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 (Use Key)	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: _____