Premier Surgery Center
OF SANTA MARIA

RECONCILIATION OF PATIENT'S MEDICATION

Patient Name :_____ Date:_____ Time:_____

Patient's Pharmacy:_____ Pharmacy's Phone:_____

Allergies: _____

***PATIENT to Complete** **NURSE to Complete (shaded section)**

*Names of Medications	*Dosages	*Frequency (when)	*Route (how)	Check with primary Care Physician before resuming ✓	Resume as pre-op ✓	Change to:	Discontinue ✓

***POST-OP MEDICATION ORDERS: Please refer to Post-Op Instructions for further information.**

Patient Signature:_____

Pre-Op Nurse Signature:_____

Discharge Nurse Signature:_____

Physician's Signature:_____

NOTE TO PATIENT: Please take this medication list to your next doctor's appointment