East Brunswick EndoscopyrCenter _____ Name

TO BE COMPLETED BY PATIENT PRIOR TO PROCEDURE

MEDICATION RECONCILIATION FORM

Allergies ***(Medication, Foods and Other Products):***

Active Medication List: ***List below all medicines you are taking at the time of admission. Include all medicines, vitamins and herbal products***

( ) Confirmed with patient in preop RN Signature:

Dosing Information Is Required If Possible

Medication Name	Dosage	Frequency	Last dose	Reason For Med	AT DISCHARGE: Continue at Discharge	AT DISCHARGE: Do Not Take upon Discharge

On No Medications

( )

MD Signature _____

PACU RN Signature _____

Copy Given to Patient

( )

Notes:

_____

_____

_____

_____

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_____

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_____

New Medicines Prescribed for Patient At Time Of Discharge

_____

_____

Information obtained by:
Patient
Bottles/List
MD Office Records