BARNABAS HEALTH
Ambulatory Care Center

**PREOP/PACU RN**

**ALLERGIES**

Medications: _____

Other: _____ Date _____

# Medication Reconciliation Form

Current Medications from home – includes prescribed, over the counter or herbal medications, and supplements

Source of Information: □ Patient □ Other _____

| MEDICATION NAME | DOSE | FREQUENCY/ ROUTE | LAST DOSE / TIME | MEDICATION NAME | DOSE | FREQUENCY/ ROUTE | LAST DOSE / TIME |
|---|---|---|---|---|---|---|---|
| ☐ **None** | | | | | | | |
| Anticoagulants/Aspirin/NSAIDS<br>□ No □ Yes □ MD notified | | | | | | | |
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| | | | | | | | |
| | | | | **SHORT TERM MEDICATIONS (3-14 days)** | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

_____ _____

Pre Op Call RN Signature Date/Time

Admitting RN Signature/Status Date/Time

**U** = unknown at this time

**List of Medications with prolonged effect, such as steroids** □ Not Applicable

| MEDICATION NAME | DATE | DOSE | SITE | INTIALS | DATE | DATE | DOSE | SITE | INTIALS |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | | | | | | | | |

_____ am/pm

Initials/Signature/Status *(of person completing section)* Date /Time

**Prescriptions written but not yet started** □ Not Applicable

**SAMPLE MEDICATIONS** □ Not Applicable

| MEDICATION NAME | DATE | DOSE | FREQUENCY / ROUTE | MEDICATION NAME | LOT # | DATE | DOSE | FREQUENC/ ROUTE |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

□ **Copy to Patient**

_____

Signature/Status *(of person completing section)* Date /Time

**Original File Copy – Duplicate Patient Copy**

des pp 5-2011