Texas Surgical Center Medication Reconciliation Form

Allergies (food, medications, latex, etc)

Name	Type of Reaction
1.	
2.	
3.	
4.	

- List **ALL YOUR MEDICATIONS** including **eye drops**, **over-the-counter** and **alternative medicines** such as vitamins, herbals, and supplements.
- It is extremely important for your care and safety that you provide complete and accurate information
- Please write if you do not know or do not remember all of the medications that you take.

Medication List

Medication Name	Dose	How do you take it?	How often do you take it?	Why are you taking this medication?	TSC STAFF USE ONLY	
					Last Dose Taken	Check √ To Discontinue
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						

Above medications should be continued at home in addition to the prescriptions below unless specified to discontinue by physician as noted above.

New Medication	Dose	Frequency	Indication/Diagnosis

It is suggested that you provide you a copy of this list for your Primary Care Provider.

Pre-Op

Reviewed day of surgery by: _____

Date: _____ Time: _____

PACU

Reviewed by: _____

Date: _____ Time: _____

Information Provided to: □ Patient □ Family □Other _____

Texas Surgical Center and its providers are not responsible for medications ordered by other organizations or providers.