GALLERIA ENDOSCOPY CENTER
MEDICATIONRECONCILIATION FORM

Patient Name:_____
Date of Birth: ____/____/_____

Allergies:_____
_____

Please include all prescription, over the counter, vitamins and herbal / natural medications taken routinely prior to admission.

Data Source: □ Patient □ Family □ Other: _____ **Patient's Pharmacy & Phone #:** _____

Medication	Dosage	Frequency	Medication Taken Day of Surgery	Resume √	Discontinue √	Add to List √
1)						
2)						
3)						
4)						
5)						
6)						
7)						
8)						
9)						
10)						
11)						
12)						
13)						
14)						
15)						
16)						
17)						
18)						
19)						
20)						
21)						
22)						

_____
Patient Signature **Date** **Signature of RN Verifying Medication List** **Date**

PHYSICIAN TO COMPLETE THIS SECTION:
□ **No change; take all medications as listed** □ **Add** □ **Change** □ **Discontinue**

_____
Physician Signature **Date**

_____
Signature of Discharge RN **Date**