Patient Name:_____

MISSION SURGERY CENTER

Medication Reconciliation List

Please include all prescriptions, over-the-counter, vitamins and herbal/natural medications taken routinely

Information Source: □ Patient □Family/Guardian □ RN

Allergies and the type of reaction you experienced:

_____

_____

Medication Name	**Dose**	**Frequency** (when and how often)	**Indication** (why do you take this)

Physician to complete this section: **Post-Op Medication Orders**

☐ **Add (see below)** ☐ **Discontinue (see below)**

_____

_____

□ Resume all medications as listed on admission

Provider Signature:_____ **Date**:_____Time:_____

Pre-op RN: _____ Date: _____

Discharge RN: _____ Date: _____ Patient Label