Treasure Coast Center for Surgery
1411 East Ocean Boulevard, Stuart, FL 34996
(772) 286-8026

MEDICATION RECONCILIATION FORM
(INCLUDING OTC, VITAMINS & HERBS)

Allergies:

Start Date if known	Drug Name	Dose	Frequency	Taken Day of Surgery	Bld. Thinners Date Stopped
☐ less than 3 months ☐ more than 3 months			☐ daily ☐ ____ x day ☐ other ____________		
☐ less than 3 months ☐ more than 3 months			☐ daily ☐ ____ x day ☐ other ____________		
☐ less than 3 months ☐ more than 3 months			☐ daily ☐ ____ x day ☐ other ____________		
☐ less than 3 months ☐ more than 3 months			☐ daily ☐ ____ x day ☐ other ____________		
☐ less than 3 months ☐ more than 3 months			☐ daily ☐ ____ x day ☐ other ____________		
☐ less than 3 months ☐ more than 3 months			☐ daily ☐ ____ x day ☐ other ____________		
☐ less than 3 months ☐ more than 3 months			☐ daily ☐ ____ x day ☐ other ____________		
☐ less than 3 months ☐ more than 3 months			☐ daily ☐ ____ x day ☐ other ____________		
☐ less than 3 months ☐ more than 3 months			☐ daily ☐ ____ x day ☐ other ____________		
☐ less than 3 months ☐ more than 3 months			☐ daily ☐ ____ x day ☐ other ____________		
☐ less than 3 months ☐ more than 3 months			☐ daily ☐ ____ x day ☐ other ____________		

Medication Information obtained from ________________________________

❑ Unable To Obtain Medication History. Reason: ________________________________

Person(s) gathering medication history: ❑ Pt ❑ Family member ________________________ Pre-Op Caller/Nurse

❑ Prescription Given **❑ No New Prescription**

Medication	Dose	Route	Frequency	Time Last Dose Given
			☐ daily ☐ ____ x day ☐ other ____________	
			☐ daily ☐ ____ x day ☐ other ____________	
			☐ daily ☐ ____ x day ☐ other ____________	
			☐ daily ☐ ____ x day ☐ other ____________	
			☐ daily ☐ ____ x day ☐ other ____________	

____ ____________

Patient's / Parent / Significant Other Signature, verifying receipt of prescription(s) Date

____ ____________

Nurse's Signature Date