PATIENT NAME _____ PATIENT ID _____ DATE _____

☐ COLON & RECTAL SURGERY ASSOCIATES
☐ VOLUSIA ENDOSCOPY AND SURGERY CENTER
☐ PORT ORANGE ENDOSCOPY AND SURGERY CENTER

SOURCE OF INFORMATION

☐ Patient Medication List ☐ Patient/Family recall ☐ Medication list from another facility
☐ Primary Care Physician ☐ Med vials ☐ H & P ☐Other_____

LATEX ALLERGIES: ☐NO ☐YES
MEDICATION ALLERGIES: ☐NO ☐YES _____

ALLERGY REACTIONS: _____

MEDICATION RECONCILIATION FORM

Current Medications (Include OTC/Herbals/Vitamins	Dose	Route	Frequency	Purpose (Cholesterol, hypertension, pain, arthritis, etc)	Last dose	Continue Medication on Discharge
						☐YES ☐NO
						☐YES ☐NO
						☐YES ☐NO
						☐YES ☐NO
						☐YES ☐NO
						☐YES ☐NO
						☐YES ☐NO
						☐YES ☐NO
						☐YES ☐NO
						☐YES ☐NO
						☐YES ☐NO
						☐YES ☐NO
						☐YES ☐NO
						☐YES ☐NO

Above is correct list of medications I am taking ***Signature Patient/Other:*** _____

Pre-Op Nurse Signature: _____ Date: _____ Time: _____

DISCHARGE MEDICATIONS: **(Only NEW medications or CHANGES in prior doses/frequency on discharge)**

Medication	Dose	Route	Frequency	Purpose	Next Dose	Instructions (if applicable)

☐ YOUR PHYSICIAN HAS REVIEWED THE ABOVE HOME MEDICATIONS AND WANTS YOU TO RESUME YOUR CURRENT REGIMEN **UNLESS** IT IS CHECKED TO NOT CONTINUE.
☐ YOUR PHYSICIAN HAS ADDED NEW MEDICATIONS AS LISTED ABOVE.

_____ _____
Patient/Other Signature Date Time Discharge RN signature Date Time

_____
Physician Signature Date Time