

INVERNESS SURGERY CENTER

Date: _____ Time: _____

Allergies: _____

- Pt/Family Recall
- Pt Medication List
- Pharmacy Contacted
- Physician Contacted
- MAR Other Facility
- Other

Include all physician prescribed/non-prescribed medications. Include vitamins and herbal supplements

Pt takes no medication.

DO NOT WRITE IN THIS SPACE

Home Medications	Dose	Route	Freq	Last Dose Date / Time	Reconcile or Discharge			Diagnostic Reason	Reason to Hold or DC Medication
					Hold	Cont.	DC		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

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

MEDICATION RECONCILIATION FORM AND DISCHARGE MEDICATIONS