Tri-State Surgery Center
Patient Medication Reconciliation Form

TSC 048A

Patient name:_____ Date of Surgery:_____
Form Completed by:_____

☐ **No Known drug allergies**

Allergies or intolerance to Medications, Food, LATEX or IV contrast

Allergy	Reaction	Allergy	Reaction
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Medications currently taking including over the counter, vitamins and herbal preparations

Current Medication	Dose	Frequency	Last Dose (NURSE ONLY)
		☐ daily ☐ twice daily ☐ as needed ☐ other	
		☐ daily ☐ twice daily ☐ as needed ☐ other	
		☐ daily ☐ twice daily ☐ as needed ☐ other	
		☐ daily ☐ twice daily ☐ as needed ☐ other	
		☐ daily ☐ twice daily ☐ as needed ☐ other	
		☐ daily ☐ twice daily ☐ as needed ☐ other	
		☐ daily ☐ twice daily ☐ as needed ☐ other	
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		☐ daily ☐ twice daily ☐ as needed ☐ other	
		☐ daily ☐ twice daily ☐ as needed ☐ other	
		☐ daily ☐ twice daily ☐ as needed ☐ other	
		☐ daily ☐ twice daily ☐ as needed ☐ other	
		☐ daily ☐ twice daily ☐ as needed ☐ other	
		☐ daily ☐ twice daily ☐ as needed ☐ other	
		☐ daily ☐ twice daily ☐ as needed ☐ other	

SURGERY CENTER USE ONLY – DO NOT WRITE BELOW THIS LINE

☐ Verified medication list with patient pre-op: _____ (initials)

NEW MEDICATION		Last Dose by Nurse

Above is a list of medications that you indicated you are currently taking. Unless otherwise noted, you should resume taking these medications. Please contact the physician who prescribed your medications if you have any questions. Medication prescribed as a result of your visit has been noted as well. Your signature below means you understand these instructions.

Patient Signature: _____
Verified: _____RN

Patient label