Heart of Texas Surgery Center / Heart of Texas Cath Lab

MEDICATION RECONCILATION FORM

Check all sources of information: ☐ Patient ☐ Significant Other ☐ Caregiver ☐ RX Bottle ☐ Other: _____

ALLERGIES / SENSITIVITES:

ALLERGY / INTOLERANCE	REACTION(S):	ALLERGY / INTOLERANCE	REACTION(S):	ALLERGY / INTOLERANCE	REACTION(S):
1.		4.		7.	
2.		5.		8.	
3.		6.		9.	

☐ **INITIATE DVT PROTOCOL RISK FACTOR SCORE** _____

MEDICATION (S) PRIOR TO ADMISSION

Patient should fill out the WHITE PART ONLY below **Shaded areas for OFFICE USE ONLY.**

MEDICATION NAME Prescriptions, OTC, Medications, Herbals, etc.	**DOSE**	**FREQUENCY**	**MEDICATION STOPPED PRIOR TO PROCEDURE(S)?** ☐ No medications stopped			**RESUME MEDICATION AFTER PROCEDURE** ☐ Resume all medication today		
			Y	**N**	**STOP DATE**	**Y**	**N**	**RESUME DATE**

MEDICATION REVIEWED BY NURSE:		**MEDICATION REVIEWED BY PHYSICIAN:**	
Date / Time	Signature	Date / Time	Signature

DISCHARGING NURSE	**MEDICATION DISCHARGE INSTRUCTIONS:**			
Signature:	☐ **New Prescription**	**Dose**	**Route**	**Frequency**
RECONCILED MEDICATION LIST RECEIVED BY:				
Signature:				
☐ **No aspirin, anti-inflammatory or anticoagulant medications (such as Advil, ibuprofen, coumadin, or Plavix) for:** _____ **Day(s).**				

Patient Label