Ridgedale Surgery Center
14 Ridgedale Avenue, Suite 120, Cedar Knolls, NJ 07927
Tel: 973-605-5151, Fax: 800-605-4456

MEDICATION HISTORY/RECONCILIATION FORM

Patient Name: _____

Date of Procedure: _____

ALLERGIES (include Medications, Food, Herbal, Latex, etc.)

☐ No Known Allergies

Allergic To:	Describe Reaction:

MEDICATIONS: List all medications

MEDICATION NAME	DOSE	ROUTE (how i.e. by mouth, etc.)	FREQUENCY (when)	LAST DOSE Date/Time	MEDICAL REASON FOR TAKING MED?	AS PER PRESCRIBING MD	As Per MD Discharge Instructions: At time of discharge, check which medications should be continued. CONTINUE AT DISCHARGE	DO NOT CONTINUE

Information Source (obtained from):

☐ Patient/Family ☐ Old records

☐ Retail pharmacy ☐ Bottles/List

☐ Other _____

Pre-op RN Signature:_____ Date:_____

Post-op RN Signature:_____ Date:_____

☐ Copy Given to Patient

New medications prescribed for patient at discharge:

Physician Signature: Date: