somenek+ pittman MD
ADVANCED PLASTIC SURGERY
SURGICAL SUITE

NAME:_____

DATE OF SURGERY:_____

MEDICATION RECONCILIATION FORM

Please list ALL medications that you currently take **(including over the counter)**, dose or strength, and the last date it was taken. Please complete this form and return it to us prior to your surgery or bring it with you on the day of surgery.

MEDICATION NAME	DOSE	FREQUENCY	DATE LAST TAKEN	RESUME POST-OP	RN VERIFIED

PLEASE LIST ALL MEDICATION ALLERGIES BELOW WITH REACTION	

Pre-Op Nurse to verify medication list

Bottom Section to be completed in the Recovery Room

❑ Resume all medications listed above, except:_____

❑ Begin post-op medications as directed on MD Discharge Instructions

❑ Medication Reconciliation Completed ❑ Copy Given to Patient

RN Signature:_____ Patient Signature:_____