## PRECISION

SURGERY CENTER OF NAPA VALLEY

## SURGICAL PATIENT MEDICATION RECONCILIATION

## PLEASE NEATLY PRINT ALL REQUESTED INFORMATION

Patient Name:			DOB:	Date of Surgery:		
Source of Information:	Patient	Family Member		🗖 Other		

Please list all current medications, including over-the-counter medications, vitamins, herbal supplements, eye drops, ointments, etc. as well as the dose or strength, the frequency (i.e. daily), and the indications.

D Please check here if the patient has an allergy to latex

D Please check here if the patient has an allergic to foods (i.e. eggs, soy), metal, dye, etc.

D Please check here if the patient has allergies to medications

(Please c	Cu omplete ONLY the shade	rrent Medication	OR to the day of your s	urgerv)			
Medication Name	Dose	Frequency	Indications	Date Last Taken	Resume at Discharge MD Use Only		
					□ Yes	🗆 No	
					T Yes	□ No	
					🗖 Yes	🗖 No	
					🗖 Yes	🗖 No	
					🗖 Yes	🗖 No	
					🗖 Yes	🗖 No	
					🗖 Yes	🗖 No	
					🗖 Yes	🗖 No	
					🗖 Yes	🗖 No	
	Now Proscripti	ons Written on Day	of Surgery		🗖 Yes	🗖 No	
Medication Name	Dose	Frequency	Indications	Begin a	Begin as Indicated		
				🗖 Ye	🗖 Yes 🔳 No		
				🗖 Ye	□ Yes ■ No		
Begin post-operative eye drop so	🗖 Ye	□ Yes ■ No					
\$	* * * DO NOT SIGN THI	S DOCUMENT BEF	ORE SURGERY * * *				

My medications have been explained to me and I understand the instructions. A copy of the instructions has been given to me.

Signature of Patient/Responsible Party

Signature of Discharge Nurse

Date

Date

Time

Time

Patient Label