PATIENT MEDICATION RECONCILIATION Form

Endoscopy Center of Topeka

Name:	Date of Birth:	Age:
Allergies: ☐ Yes ☐ No known allergies	Latex Allergy ☐ No ☐ Yes ☐ Testing performed for Latex allergy	

Allergy (Drug)	Reaction	Allergy (drug)	Reaction

Current Prescriptive Medications.

Name of Medication (print please)	Dose	Last Dose Taken/Time	How Often	Continue After Discharge	Stop After Discharge

Herbals, Vitamins, Supplements, Non-Prescriptive Drugs.

Name of Medication (print please)	Dose	Last Dose Taken/Time	How Often	Continue After Discharge	Stop After Discharge

Signature of person filling out form_____ Date:_____

New Medications or New Dosages you should take after discharge.

Name of Medication (print please)	Dose	How Often

Signature of Patient/Responsible Person: _____ Date:_____

Nurse Signature:_____ Date:_____

Physician Signature:_____ Date:_____