BAYLOR Orthopedic and Spine Hospital at Arlington

MEDICATION RECONCILIATION

Primary Care Physician Name:_____

Information provided by: Patient ☐ Family ☐ Friend ☐ Other_____, Unable to obtain due to patient condition ☐ Patient knowledge of medication ☐

Allergies:_____ Latex ☐ Tape ☐ Iodine ☐

(include all herbals, prescription and non-prescription medications, supplements, eye drops, inhalers, etc.)

Drug Name and Dosage (Avoid abbreviations of any kind) Indications may be included if needed	**Route**		**Frequency** (Avoid abbreviations of any kind)	**Last taken Date/time** (On Date of Service)	**For Pain Patients**	
	By mouth	Other (i.e. patch, rectal, etc.)				
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						

1st Admission
Pre-Op Nurse:_____Date/Time:_____

OR/Procedure Circulator:_____Date/Time:_____

2nd Admission ☐ **No changes from previous admission, if within 90 days of last date of service**
Pre-Op Nurse:_____Date/Time:_____

OR/Procedure Circulator:_____Date/Time:_____

3rd Admission ☐ **No changes from previous admissions**
Pre-Op Nurse:_____Date/Time:_____

OR/Procedure Circulator:_____Date/Time:_____

New/Changed Drug Name and Dose (Avoid abbreviations of any kind) Indication may be included if needed	**Route**		**Frequency**	**Instructions given on medication, dose, frequency, side effects, next dose.**	
	By mouth	Other (i.e., patch, rectal, etc.)		Next dose	Nurse initials
1.					
2.					
3.					
4.					
5.					

The listed medications are correct. I, undersigned, have read and understand these instructions.

Signature of patient or authorized representative Date/Time Signature of nurse reviewing discharge instructions Date/Time

VMR-[CaseId]-775-1

NAME:**[PatientLast], [PatientFirst]**
ACT#: **[PatientId]**
DOB: **[DOB]** AGE: **[Age]** SEX: **[Sex]**
DR: **[PhyLast], [PhyFirst]**
ADMIT DATE: **[DOS]**