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.

- ❒ Please check here if the patient has an allergy to latex
- ❒ Please check here if the patient has an allergic to foods (i.e. eggs, soy), metal, dye, etc.
- ❒ Please check here if the patient has allergies to medications

Current Medication (Please complete ONLY the shaded information PRIOR to the day of your surgery)					
Medication Name	**Dose**	**Frequency**	**Indications**	**Date Last Taken**	**Resume at Discharge**
				For RN/MD Use Only	
					❒ Yes ❒ No
					❒ Yes ❒ No
					❒ Yes ❒ No
					❒ Yes ❒ No
					❒ Yes ❒ No
					❒ Yes ❒ No
					❒ Yes ❒ No
					❒ Yes ❒ No
					❒ Yes ❒ No
					❒ Yes ❒ No
New Prescriptions Written on Day of Surgery					
Medication Name	**Dose**	**Frequency**	**Indications**	**Begin as Indicated**	
				❒ Yes ■ No	
				❒ Yes ■ No	
Begin post-operative eye drop schedule per your doctor's instructions				❒ Yes ■ No	
✱ ✱ ✱ DO NOT SIGN THIS DOCUMENT BEFORE 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 _____ Date _____ Time _____

Signature of Discharge Nurse _____ Date _____ Time _____

Patient Label