

# Naugatuck Valley Surgical Center MEDICATION RECONCILIATION

Name: \_\_\_\_\_

Physician: \_\_\_\_\_ Date of Procedure: \_\_\_\_\_

Medication Allergies and Reactions: \_\_\_\_\_

Please list your prescription medications including dose and frequency. Also include any pills, including vitamin supplements, herbal preparations, cold medications, and diet pills you are currently taking. If you currently are taking any Aspirin, or Aspirin products, blood thinners, or Ibuprofen containing products (see enclosed list), please list and contact your physician to see if you should discontinue these products prior to your procedure:

<u>Medication</u>	<u>Dosage</u>	<u>Frequency</u>	Completed By NVSC Last Taken	DISCHARGE MEDICATIONS				
				Continue	Stop ●	Contact PMD*	Resume Date	M.D. Initials
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

<p><b>*DO NOT WRITE BELOW THIS LINE - Area below to be completed by NVSC</b></p> <p>Medications verified with patient by _____ R.N.</p> <p>Medications received <u>Pre</u> or <u>Post</u> procedure: (other than eye drops)</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;"><u>Medication</u></th> <th style="width: 25%;"><u>Dosage</u></th> <th style="width: 25%;"><u>Time Given</u></th> <th style="width: 25%;"><u>Administered for:</u></th> <th style="width: 20%;"><u>R.N. Signature</u></th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	<u>Medication</u>	<u>Dosage</u>	<u>Time Given</u>	<u>Administered for:</u>	<u>R.N. Signature</u>																<p><b>*Consult your prescribing practitioner regarding the continuation of this medications</b></p>
<u>Medication</u>	<u>Dosage</u>	<u>Time Given</u>	<u>Administered for:</u>	<u>R.N. Signature</u>																	

Discharge prescription provided to patient for pharmacy filling: (as provided by M.D.)

\_\_\_\_\_

\_\_\_\_\_

Medication Reviewed and Reconciled by: _____ M.D.	Anesthesiologist _____ M.D.
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**Anesthetic medications received intra-procedure: Other:** \_\_\_\_\_

<input type="checkbox"/> Propofol	<input type="checkbox"/> Oxygen	<input type="checkbox"/> Sevofluorane	<input type="checkbox"/> Reglan	<input type="checkbox"/> Toradol	<input type="checkbox"/> Betamethasone	<input type="checkbox"/> Depomedrol
<input type="checkbox"/> Versed	<input type="checkbox"/> Nitrous Oxide	<input type="checkbox"/> Zemuron	<input type="checkbox"/> Decadron	<input type="checkbox"/> Tylenol	<input type="checkbox"/> Marcaine	<input type="checkbox"/> Kenalog
<input type="checkbox"/> Fentanyl	<input type="checkbox"/> Forane	<input type="checkbox"/> Zofran	<input type="checkbox"/> Morphine	<input type="checkbox"/> Ancef	<input type="checkbox"/> Omnipaque	<input type="checkbox"/> Lidocaine

Patient Signature \_\_\_\_\_ R.N. Signature: \_\_\_\_\_