Patient Medication Reconciliation Form: North Shore Endoscopy Center

List all prescription, non-prescription medications, and supplements. Include the dose, how often taken, and the last taken dose.

Allergies: ☐ Yes ☐ No known allergies		Latex Allergy ☐ Yes ☐ No	
Allergy (Drug)	**Reaction**	**Allergy (drug)**	**Reaction**

Current Prescriptive Medications.

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

Herbals, Vitamins, Supplements, Non-Prescriptive Drugs.

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

New Medications or New Dosages you should take after discharge.

Name of Medication (print please)	Dose	How Often

Signature of Patient/Responsible Person:______________________________Date:_______________

ADM RN Signature:___________________________/ PACU RN ___________________________ Date:_______________

Physician Signature:__________________________Date:_______________