New Braunfels Surgery Center Medication Reconciliation Form

Allergies (food, medications, latex, etc.)

Name	Type of Reaction
1.	
2.	
3.	
4.	

- List **ALL YOUR MEDICATIONS** including, **eye drops**, **over-the-counter** and **alternative medicines** such as vitamins, herbals, and supplements.
- It is extremely important for your care and safety, that you provide complete and accurate information
- Please write if you do not know or do not remember all of the medications that you take.

Medication List **[STAFF USE ONLY]**

Medication Name	Dose	How do you take it?	How often do you take it?	Why are you taking this medication?	Last dose taken	Medication	
						Added	Deleted
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

****It is suggested that you provide a copy of this list to your Primary Care Provider.****

Medication history recorded & verified by: _____ **Date:** _____
[Print name]

Medications Reconciled by: _____ **Date:** _____
[Name of Healthcare Provider]

Copy of MRF Given: _____ **Date:** _____
[Post-op nurse's signature]

Signature of patient/guardian	Date	Nurse Signature	Date
Signature of patient/guardian	Date	Nurse Signature	Date
Signature of patient/guardian	Date	Nurse Signature	Date
Signature of patient/guardian	Date	Nurse Signature	Date

New Braunfels Surgery Center and its providers are not responsible for medications ordered by other organizations or providers

PATIENT LABEL