Medical Reconciliation

PATIENT LABEL

NAME: ____ DATE OF PROCEDURE: _________________

☐ No Known Drug Allergies
☐ Allergies as follows (Please describe reaction)

Please list medications, doses, frequency, and date last taken ONLY:

Medication/Dose/Frequency	Date Last Taken	Route	RN Check/Initial	Discontinue	MD Check/Initial

_____Continue all medications
_____Provider's Initials

Instructions/New Medications:

Provider's Name/Date: ____

RN's Name/Date: ____