PATIENT MEDICATION RECONCILIATION FORM

MINNEAPOLIS EYE CENTER

Name:	Date of Birth:	Age:
Allergies ☐ Yes ☐ No known allergies		

Medication Allergy	Reaction	Medication Allergy	Reaction

Current Prescriptive Medications. (Please attach and additional form if needed)

Name of Medication (print please)	Dose	How Often Do you take it?	Continue After Discharge	Stop After Discharge

Herbals, Vitamins, Supplements, Non-Prescriptive Drugs.

Name of Medication (print please)	Dose	How Often do you take it?	Continue After Discharge	Stop After Discharge

New Medications or New Dosages you should take after discharge.

Name of Medication (print please)	Dose	How Often to take	Continue After Discharge	Stop After Discharge

Signature of Patient/Responsible Person:_____**Date:**_____

☐ **Medication reconciliation reviewed verbally and a signed copy given to patient.**

RN Signature:_____**Date/time:**_____