ATLANTA ENDOSCOPY CENTER

2665 NORTH DECATUR ROAD
DECATUR, GA 30033
404-297-5000

(Medication Reconciliation)

DOS: _____

PATIENT NAME: _____ DOB: _____

MRN# _____

ALLERGIES: _____

*LIST BELOW ALL OF THE PATIENT'S MEDICATIONS **PRIOR TO PROCEDURE** INCLUDING OTC AND HERBAL MEDS*
NEW MEDICATIONS OR MEDICATION CHANGES SHOULD BE WRITTEN ON DISCHARGE ORDERS

Source of Medication list: (check all used)

- ☐ Patient medication list
- ☐ Patient/Family recall
- ☐ Pharmacy _____
- ☐ Primary care physician list
- ☐ Physician order list
- ☐ Medication Administration Record from facility
- ☐ Other:

MEDICATION HISTORY RECORDED/VERIFIED BY: _____

MEDICATION NAME (WRITE LEGIBLY)	DOSE (mg, mcg,)	ROUTE (PO, GT, SC, IV)	FREQUENCY	LAST DOSE DATE/TIME	*CIRCLE C to continue OR DC to discontinue* PHYSICIAN ORDER Continued on Admission	Drug clarification required Hold until clarified with MD	Dose clarification required Hold until clarified with MD
1.					C DC	☐	☐
2.					C DC	☐	☐
3.					C DC	☐	☐
4.					C DC	☐	☐
5.					C DC	☐	☐
6.					C DC	☐	☐
7.					C DC	☐	☐
8.					C DC	☐	☐
9.					C DC	☐	☐
10.					C DC	☐	☐
11.					C DC	☐	☐
12.					C DC	☐	☐
13.					C DC	☐	☐
14.					C DC	☐	☐
15.					C DC	☐	☐

Patient Signature _____ Date _____

RN Review _____ Date _____

MD Review _____ Date _____