HVAS Hudson Valley Ambulatory Surgery, LLC
Same Day Surgery Experts
75 Crystal Run Road, Building B, Suite 225, Middletown, NY 10941 T: (845) 692-9900 F: (845) 692-0800

Medication Reconciliation Record (Page 1 of 2)

PATIENT NAME:_____

PATIENT ADDRESS:_____

DATE OF BIRTH:_____ ☐ MALE ☐ FEMALE

SURGEON:_____ DATE OF SERVICE:_____

Home Medications / Dose / Route / Time (Include Herbal / OTC / Vitamins)

☐ Patient takes no medications
☐ New medication ordered Date:_____

Medication Name:	Dose:	Route:	Frequency:	Last dose taken Date / Time

New Medication:	Dose:	Route:	Frequency:	Last dose taken Date / Time

I have obtained the patient's home medication listed above.
Nurse signature _____ Date _____

I have reviewed home medications with patient prior to procedure & noted last dose taken.
Nurse signature _____ Date _____

I have reviewed patient's home medications prior to procedure & have continued or changed medication orders after the procedure as noted above.
Physician signature _____ Date _____

I have received a copy of my medication list and understand my instructions.
Patient signature _____ Date _____

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Additional Medications Please name:	Dose:	Route:	Frequency:	Last dose taken Date / Time

ALLERGY TO LATEX?	☐ **YES** ☐ **NO** **(Please check one)**

Please list all known allergies, including medication, environmental, and food, and allergic reaction

Name:	Reaction

Submit Form