TEXAS GI ENDOSCOPY
MEDICATION RECONCILIATION FORM

Patient: _____ **Date:** _____

Allergies/ Reactions: _____

_____

Pre-Procedure Medications: provided by patient

Medication	Dose	Frequency	Indication	Last Dose Taken

Admit RN: _____

Post –Procedure

Medications Changed	Dose	Frequency	Comments

Medications Added	Dose	Frequency	Comments

We have noted all the medications you are currently taking. The list is prepared based on the information you have provided to us.
This facility is not responsible to maintain, prescribe or refill any of the above medication.
Please call the office of the prescribing physician for medication refills or questions.

Patient / Patient Representative Signature: _____

Discharge Nurse's Signature: _____