Pacific Heights
SURGERY CENTER

MEDICATION LIST

Please bring with you Day of Surgery OR Fax to: 415.567.1181

PATIENT NAME AND PHONE NUMBER: _____

PRIMARY DOCTOR'S NAME AND NUMBER: _____

PHARMACY AND PHONE NUMBER: _____

Medication Reconciliation List

(Including prescriptions, over the counter medications, herbals, vitamins/minerals and birth control pills/patches)

MEDICATION NAME	DOSE	FREQUENCY (how often)	REASON FOR TAKING	LAST TAKEN

ALLERGIES/SENSITIVITES	TYPES OF REACTION NOTED

RN Signature _____ Date _____ Time _____

RN Signature _____ Date _____ Time _____

Patient Name: _____

Case No. _____