WINDHAVEN
SURGERY CENTER

MEDICATION RECONCILIATION FORM

Source of medication list (check all used)
□ Patient □ Family member/guardian/caregiver □ Primary care physician list

	ALLERGIES (medication & Food)	REACTION
1		
2		
3		
4		
5		

	Medication list	Dose	Frequency	Last time taken?	Continue			Restart DATE
					YES	HOLD	NO	
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

Medication history verified by RN: _____ Date/Time: _____

IN ADDITION TO THE PRESCRIPTIONS BELOW, THE ABOVE MEDICATIONS SHOULD BE CONTINUED AT HOME UNLESS SPECIFIED BY A SURGEON TO HOLD OR DISCONTINUE	
SIGNATURE OF SURGEON REVIEWING MEDICATIONS (REQUIRED)	_____ Date/Time: _____

PRESCRIPTIONS GIVEN TO PATIENT UPON DISCHARGE						
	Medication Name	DOSE	ROUTE	FREQUENCY	REASON FOR MEDICATION	NEXT DOSE @
1						
2						
3						
4						
5						
6						

□**NO NEW PRESCRIPTIONS**

Medication/prescriptions reviewed, copies given to patient/responsible adult verbalizes understanding

Signature patient/responsible adult _____

Discharged nurse signature: _____ Date/Time: _____

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Preadmission Questionnaire

Date of Surgery: Scheduled Time of Surgery: Arrival Time:
Surgeon: Ride/Caregiver Name: Contact #:
Pt explanation of procedure :_____

Preferred Language: □English □Other: **Translator requested/needed □NO □YES**

Do you have any problems/side effects with anesthesia □ Self □ Family History _____

□**NKDA**
□Allergies _____
□Betadine _____
□Adhesive _____
□Latex _____

_____
_____
_____
_____

YES	NO	MEDICAL HISTORY Source of Information: □Patient □Parent □Prior Visit □Physician H&P
		CARDIAC: □Angina □Hypertension □Arrhythmia □Valve Disease _____ □CAD □HLD
		CARDIAC/SX: □CABG_____ □Valve Replacement_____ □Stent Placement_____ □Aneurysm size_____ □MI _____ □ICD/PPM
		PULM: □Pulmonary Fibrosis/HTN □Asthma □COPD □OSA □CPAP □Snores
		ENDOC: □DM1 □DM2 □Hypo Thyroid □Hyper Thyroid □Cushing's □Other_____
		NEURO: □Strokes □TIA □Seizures_____ □MS □Dementia □Parkinson □Muscular Disorders_____ □Migraines
		GI/GU: □GERD □PUD □ Hiatal Hernia □Kidney/Liver/ Urinary Disease _____
		INFECTIOUS: □MRSA □VRE □ C.DIFF □ HIV/AIDS □HEP_____ □TB □Shingles
		Recent: □ Cold □ Fever □ Flu □PNEUM/Bronch_____
		IMM/HEM: □ Bleeding/Clotting Disorder □ Anemia □ Other:_____
		RHEUM: □Autoimm DX_____ □Anemia_____
		ONCOLOGY: □Cancer_____ □Chemo □Radiation □Lymphedema/Limb Alert_____
		MUSC/SKEL: □Arthritis_____ □Weakness □Numbness □Neuropathy □Neck □Back
		PSYCH/SOCIAL: □Depression □Anxiety □Suicidal Thoughts □Abuse/Neglect □PTSD □Bipolar □Schizophrenia

Alcohol Use □ Never □ Occasional □ Daily_____ □ Weekly_____
Tobacco □ N/A ☐ PPD_____Yrs □ Quit_____Yrs. Ago □ Recreational Drugs_____

Assistive Devices: □ Glasses □ Contacts
□ Dentures □ Partials □ Hearing Aids □ Cane □ Crutches □ Walker □ E/C □Hardware/Implants_____

SURGERIES:_____
_____

PRE-OP INSTRUCTIONS **□ N/A QUESTIONNAIRE DONE DAY OF PROCEDURE**

□ Drink plenty of water the day before surgery to keep well hydrated
□ Nothing to eat or drink after midnight (Including water, juice, coffee, ice chips, chewing gum, and mints).
□ Please take the following medications the morning of the surgery with a tiny sip of water:
□ BP med □ Heart med □ Seizure Med □ Resp Med □ Other
□ Stop Blood Thinners, NSAIDS, Aspirin, or Fish Oil
□ Wear loose confortable clothing, Bring your inhaler, contact case, or anything you were instructed to bring the DOS.
□ NO shaving of operative site

Pre-Op Call: Date: **Time:** **□ No answer** **Date:** **Time:**
Initials: **Signature:**

□ REFERRED TO ANESTHESIOLOGIST/ MD FOR REVIEW