MedStar Health

DAY OF PROCEDURE PATIENT MEDICATION LIST

Date: ______________________________

Patient's Full Name: ____________________________________ **Patient's Date of Birth**: ______________________

If the patient has already reviewed this information with the surgeon's office or the Pre-Anesthesia team, a pre-op nurse or clinician must confirm and document medications and allergies **on the day of the procedure** for the safety of our patients.

The patient should print and complete the document and bring it to the hospital on the day of the procedure. If unable to print the document, write the medication information on another piece of paper and bring a copy to the hospital.

If the patient takes insulin, please include the medication name, amount, and time(s) of the day.

Medication Name(s) Prescription(s), Over-The-Counter Medication(s), Vitamin(s) and Supplements	**Amount** (mg, units, etc.)	**Frequency** (AM, PM, 3x/day, etc.)	**Date/Time Last Dose was Taken**

Patient's Full Name: ____ **Patient's DOB**: _____________________

Is the patient allergic to any medication(s)? ☐ Yes ☐ No

If **yes**, please provide the name(s) of the medication(s) and the patient's reaction(s) in the table below:

Name of the Medication(s)	Allergic Reaction(s) Description

PRINT AND BRING BOTH MEDICATION DOCUMENTS WITH YOU TO THE HOSPITAL ON THE DAY OF YOUR PROCEDURE