The Center for Outpatient Medicine, LLC <Patient Label>

MEDICATION LIST

Patient Name:_____ **Birthdate:**_____ **Surgeon:**_____

- **PLEASE CHECK HERE IF YOU DO NOT TAKE ANY MEDICATIONS** ☐
- **Which pharmacy do you have your prescriptions filled at:** _____
- **Please list all your medications including PRESCRIPTIONS, VITAMINS, HERBALS, OVER THE COUNTER MEDICINES, and DIETARY SUPPLEMENTS.**
- **Please include the amount (in milligrams if applicable) and how frequently you take it.**
- **Please list all allergies, including those to medications, food, latex or rubber.** _____

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- **PLEASE DO NOT FILL OUT THE "RESUME"/"DO NOT RESUME" COLUMNS BELOW. THEY ARE TO BE FILLED OUT BY YOUR SURGEON THE DAY OF THE SURGERY.**
- **If additional space is needed please use the back. Please send this list in before your surgery along with your pre-anesthesia questionnaire (pink sheet).**
- **If the surgeon orders any medications for you at the time of your surgery we will add it to the list.**
- **A copy of this list will be given to you upon discharge to give to your doctor or caregiver at your next appointment. This list is another way we are trying to ensure your safety.**
- **You can use the copy to update the information on this sheet when medications are deleted, doses are changed, or new medications (including over the counter products) are added.**
- **You should carry medication information at all times in the case of emergency situations.**

							RCC ONLY: DISCHARGE MEDICATIONS	
Medication Name	**Dose / Milli-grams (how much)**	**Route (how taken)**	**Frequency (how often)**	**Purpose (why you take)**	**Resume**	**Do Not Resume**	**Resume**	**Do Not Resume**
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*Based on your visit at TCOM, you may safely continue the medications checked "resume". If you have any questions, please contact your prescribing physician.

Medications Prescribed Upon Discharge

Surgery Center Discharge:

Surgeon Signature: _____ Date _____

Nurses Signature: _____ Date _____

☐ **List provided and explained to patient and/or responsible adult** ☐ **Faxed to next provider of care**_____ ☐ **Copy given to patient**

Bromenn Comfort and Care Discharge:

Surgeon Signature: _____ Date _____

Nurses Signature: _____ Date _____

☐ **List provided and explained to patient and/or responsible adult** ☐ **Faxed to next provider of care**_____ ☐ **Copy given to patient**

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RCC ONLY: DISCHARGE MEDICATIONS

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Surgery Center Discharge:

Surgeon Signature: ____ Date ________________

Nurses Signature: ____ Date ________________

☐ **List provided and explained to patient and/or responsible adult** ☐ **Faxed to next provider of care___________** ☐ **Copy given to patient**

Bromenn Comfort and Care Discharge:

Surgeon Signature: ____ Date ________________

Nurses Signature: ____ Date ________________

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