Crystal Run
Ambulatory Surgery Center

95 Crystal Run Road
Middletown, NY 10941
845-703-3800

Medication Reconciliation and Orders

Date: _____

Source Information (Check all that apply)	**Home Medications Include:**
☐ Patient's own medication list ☐ Patient/Family Recall ☐ Physician Office ☐ H & P ☐ Other: _____	• Prescription medications or sample medications • OTC medications • Vitamins • Nutraceuticals • Vaccines • Diagnostic Imaging Contrast

Current Home Medications: Please complete using patients terminology (by mouth, 3 times a day, etc.)

Medication	**Dose**	**Route**	**Frequency**	**Last Taken:** Date & Time	**Continue Medications? Yes or No**
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New Ordered Medications: Please complete using patient's terminology (by mouth, 3 times a day, etc.)

Medication/Food Allergies:

Additional Notes: _____

I have obtained the patient's home medications listed above. I have reviewed home medications list with patient prior to procedure and noted last dose taken.	Nurses Signature	Date
I have reviewed patient's home medications prior to procedure and have continued or changed medications orders after the procedure as noted above.	Physician Signature	Date
I have received a copy of my medication list and understand my instructions.	Patient Signature	Date