Mid-State Endoscopy Center- Medication Reconciliation Form

Patient: _____ **Primary Physician:** _____

ALLERGIES (food, medications, latex, etc):

Name	Reaction
1	
2	
3	
4	
5	
6	
7	

MEDICATION LIST (Staff Use Only)

Medication Name	Dose	How Taken	How Often	Last dose taken	Medication		HealthCare provider signature if change made
					Added	Deleted	
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							

Medication history recorded by: _____ **Information verified by:** _____
Print Name — Healthcare Provider's Signature

Medications Reconciled: _____ **Date & Time:** _____
HealthCare Provider's Signature

Copy of MRF Given: _____ **Date & Time:** _____
Post-op nurse's Signature

* Mid-State Endoscopy Center and its providers are not responsible for any medications ordered by another organization or provider