AAAHC
ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

Patient Medication Reconciliation Form in Surgical/Procedural Setting

Patient Name: ______________________________ Patient Preferred Pharmacy Name/Phone #: ______________________________

Source of Medication List *(Check All That Apply)*: ❏ Patient Interview ❏ Patient's Own List ❏ Caregiver Interview ❏ Pharmacy
❏ State Prescription Drug Monitoring Program (POMP) ❏ Primary Care Provider ❏ Surgeon ❏ Other, please specify: ______________________

Allergies (include drug and materials)	Reaction

PRE-OPERATIVELY						Stop Medication Prior to Procedure (YES/# of days prior or NO)	POST-OPERATIVELY	
Routinely Taken Medications (includes OTC)	Dose	Frequency	Indication	Start Date	Prescriber		Continue Medication after the Procedure (YES/# of days after or NO)	Comments

New Prescriptions Added Post-Operatively					
Medication	Dose	Frequency	Start Date	Prescriber	Comments

Patient Signature: ______________________Date: __________ Provider Completing Form: ______________________ Date: __________

**NOTE: IF THERE ARE ANY DISCREPANCIES IN THIS FORM COMPARED TO INFORMATION CONTAINED IN THE PATIENT'S MEDICAL RECORD, RESOLVE THE ISSUES BY CONTACTING THE PHARMACY, PRESCRIBING PHYSICAN, AND/OR THE PATIENT.

06/18