

Please fill out the highlighted areas and return to The Williams Center

NEW ENGLAND LASER AND COSMETIC SURGERY CENTER, LLC
 MEDICATION RECONCILIATION FORM

Name _____

ALLERGIES: (NKA) LATEX (SEE ATTACHED LATEX ALLERGY FORM) OTHER – LISTED BELOW

DATA SOURCE: PATIENT FAMILY BOTTLES/LIST OTHER _____

DO NOT USE THESE ABBREVIATIONS: QD, QOD, MS, MSO4, MgSO4, .U, U, OR IU
 Do Not use a trailing zero (X.0 mg) – Write instead Xmg Use a leading zero – write 0.Xmg

Include all prescriptions, over the counter, vitamins, supplements, and herbal or natural medications taken routinely prior to admission. (Nurse, Patient, or Family to complete this section)	PHYSICIAN COMPLETES: Post-Op Medication Orders
---	--

Medication Name	Dose	Route	Frequency	Last Dose Taken	Resume as Pre-op <input type="checkbox"/>	Discontinue <input type="checkbox"/>

START the following MEDICATION

Medication Name	Dose	Route	Frequency	Prescription Given	Instructions
				<input type="checkbox"/> NELCSC <input type="checkbox"/> OFFICE	
				<input type="checkbox"/> NELCSC <input type="checkbox"/> OFFICE	
				<input type="checkbox"/> NELCSC <input type="checkbox"/> OFFICE	

Signature of person obtaining original information _____ Date & Time _____

Signature of Pre-op Nurse _____ Date & Time _____

Signature of Post-op Nurse _____ Date & Time _____

Note to Patient: Please take this medication list to your next Doctor's appointment. It is recommended that you bring a list of your current medications to each medical appointment.

Signature of Patient _____ Date & Time _____

Physician's signature: _____ **Date & Time** _____