At Gastro One and the GI Diagnostic and Therapeutic Center, medication safety is a top priority. We want to assure that we have full knowledge of all of your current medications so that we may safely administer new drugs during your procedure and avoid duplication of drugs or dangerous interactions. This is called "Medication Reconciliation".

You can help us by completing the section marked on the back of this form and bringing it with you on the day of your procedure.

When your procedure is completed medications you received during or after your procedure will be added to the form along with any prescriptions you are given. Upon discharge you will be given a copy of the completed form for your personal records so that your next provider of care will have full knowledge of your current medications. We recommend that you keep a copy of this form in your wallet for easy access.

The physicians of Gastro One

GI DIAGNOSTIC AND THERAPEUTIC CENTER, LLC MEDICATION RECONCILIATION

NAME:________________________________ CHART:__________ PROCEDURE DATE:____________

Medications verified by______________________ with ☐ Patient ☐ Family ☐ Other: _______________

☐ No known allergies or sensitivities ☐ Allergies ____

____

Section 1

List all medications that you take regularly or as needed including over the counter & herbal medications

To be completed by the Patient			To be Completed by Nurse/MD			
Medication Name	**Strength**	**How many times per day?**	**Date last taken**	**Restart now**	**Restart on the specific date marked**	**Restart as needed**
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
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				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
☐ see Next Page				☐	☐	☐

Section 2

During your procedure you were given:	**In the Recovery Room you were given:**
Yes No ☐ ☐ Propofol with Lidocaine for sedation ☐ ☐ Propofol only for sedation ☐ ☐ Other medications:________________ ______________________________________	☐ No Medications ☐ Other _______________________________ ______________________________________ ______________________________________

Section 3

New prescriptions given today at discharge ☐ **None**	Dose	Frequency

MD Signature: ____ **Date:** ___________________________

☐ **Form reviewed with patient and copy given.** **RN signature** ____________________ **Date:** __________