Belleville Surgical Center
an affiliate of ***SCA***

Please Print Your Name: _____

Patient Home Medication List

Home medication list as provided by Patient

Please include all prescription medications as well as Over the Counter medicines, Herbs, and Vitamin Supplements.

~~For Staff Only~~

Medication Name	Dose	Frequency	Reason for Taking	Last Taken	Pre-op Notes

Asterisk (*) in "Pre-op Notes" column denotes medication that patient was told to take the morning of surgery with sips of water

~~~~~~~~~~~~~~~~~To be completed by Surgical Center Staff~~~~~~~~~~~~~~~~~~

Medications verified day of surgery: _____

New Prescriptions	Dose	Frequency	Reason for Taking	Last Taken	Notes

Allergies/reactions (including meds, foods, latex): _____

Signature Review of Medications and Allergies across the patient care continuum:

Anesthesiologist: _____ CRNA: _____

Surgeon: _____ OR Nurse: _____

PACU: _____

Patient/Responsible Party Signature Upon Discharge: _____
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