PLEASE BRING TO THE SURGICAL SUITES ON DAY OF SURGERY!

Patient's Current Medication Record

Please list all medications (prescriptions, over-the-counter, herbal, etc.) in all forms that you are currently taking. Clearly list the names as they appear on the product's packaging.

ALLERGIES: ____

NAME OF MEDICATION	STRENGTH / DOSAGE (mg, ml, etc.)	FREQUENCY TAKEN (Number of times/day, week, etc.)	FORM OF ADMINISTRATION (Pill, Injection, Cream, etc.)

□ I do not know what medication I am currently taking.

MEDICATIONS RECEIVED FOR SURGERY AT THE SURGICAL SUITES– SEE ATTACHED SHEET

I hereby acknowledge that the above list is accurate, complete and represents the medications that I am currently taking as of _____________ (today's date.) Should this document need to be transmitted to (shared with) another healthcare provider as part of my continuing medical care, I hereby authorize its release to those health care providers to which I have need transferred. This is protected health information and shall be treated accordingly.

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PATIENT SIGNATURE DATE