WINCHESTER HOSPITAL
Winchester, Massachusetts

Endoscopy Medication Reconciliation List

Allergies: _____ **Date** _____ **Time** _____

_____

Information Obtained*:** ☐ ***Patient ☐ ***Family*** ☐ ***Provider List*** ☐ ***Pharmacy*** ☐ ***Prior Hospital Record***
☐ ***List/Bottles*** ☐ **Other:** _____

Home Medications: List all medications, nutritional, herbal supplements, and pumps and patches used prior to this visit or admission.

☐ **No Medication Prior to Admission**

Medication Name	Direction (Dose, Route, Frequency)	Indication (Reason)	Last Dose (Date / Time)	Comments / Changes

Pre-procedure Nurse Signature documenting medication list: _____ **Date** _____

Pre-Procedure Nurse Signature documenting last dose: _____ **Date** _____

Comments / Changes	New Medication Instructions

Discharge Medication Reviewed By: _____ **MD Signature** **Date:** _____

(I have reviewed home medications, orders previously written. This does not constitute an order. It is not my intent to alter the patient's medications unless specifically indicated in the comment /changes. Any questions about changes should be discussed with the patient's primary care physician or applicable specialist.)

Post-Procedure RN _____ **Date:** _____

Medication Reconciliation was reviewed with me and copy given to patient/sponsor.

Patient/Sponsor Signature: _____ **Date:** _____