Medication List

Procedure Date ____/____/____

Patient Name: _____ Date of Birth ____/____/____

Allergies:

_____ _____ _____

_____ _____ _____

* LIST ALL MEDICATIONS INCLUDING VITAMINS, ASPIRIN, OVER THE COUNTER, AND HERBAL MEDICATIONS			ADDITIONAL INSTRUCTIONS REGARDING MEDICATIONS POST PROCEDURE (IF APPLICABLE)
Medication Name	Dose	How many times a day do you take it?	

*The above list is a list of medications that you provided to us upon your admission to the Center. This is not a physician's order.

☐ Patient/Family ☐ Bottles/List ☐ Physician Office Records ☐ Pharmacy

O **Please wait ____ days** before resuming blood thinners (such as Coumadin, Plavix, Aspirin, or other).
O You may resume all **other** previous medications, unless otherwise stated here: _____

New Medications to Take Following this Procedure:

_____

_____

White – Facility Copy Yellow – Patient Copy