SurgiCare ***of Manhattan, LLC***

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Patient Label

Medication Reconciliation Record

Patient Name:_____ **Date:**_____ **Doctor:**__**STUART KATCHIS, M.D.**_____

☺ The easiest way to do this is to line up all your medicine bottles or packages and copy directly off of them. ☺

Reminder Checklist

- **Aspirin, Motrin, Advil, Ibuprofen, Aleve, Naproxen, or other pain relievers.**
- **Allergy medicine**
- **Antacids**
- **Anti-fungal**
- **Antibiotics**
- **Contraceptives**
- **Cold, flu or cough Medicines**
- **Blood pressure or heart medicines**
- **Decongestants**
- **Hormones**
- **Laxatives**
- **Medication patches**
- **Sleeping pills**
- **Weight loss pills**
- **Vitamins, Minerals**
- **Herbal remedies or supplements**

Name of Medication *This also includes over the counter medications*	How much do you take?(dose)	When & how do you take it?	Why do you take it?	Continue taking these as ordered by the prescribing doctor(s)		Special Instructions
				Yes (√)	No (√)	

New Medications to be taken at home

Name of Medication	How much to take (dose).	When & how to take it.	Why you are taking it.	Special Instructions

I HEREBY ACKNOWLEDGE THAT THE INSTRUCTIONS HAVE BEEN EXPLAINED TO ME AND THAT I FULLY UNDERSTAND THEM.

_____ _____ _____ _____ **Copy given to patient by_____(Initial)**

Patient Signature **Date** **Nurse's Signature & Initial** **Date** **Copy given to MD by_____(Initial)**