MEDICATION LIST & RECONCILIATION

Patient sticker

Please list all medications you are taking, including over-the-counter, vitamins, and herbal products.

DO YOU TAKE ANY BLOOD THINNERS? ❑No ❑Yes: _____

Medication	Dose	Route	Frequency	Date/Initials (staff only)							

DO NOT WRITE BELOW. FOR STAFF USE ONLY *(ED207) (05/16)*

ALLERGIES:	
Initials/Signature	

Medication	PT/INR/date	Last dose