

MEDICATION RECONCILIATION FORM

Name: _____ Date: _____

Height: _____ ft. _____ in. Weight: _____ lbs.

Drug Allergies YES NO Food Allergies YES NO

Describe Allergies (if applicable) _____

Language needs: English Spanish Other _____

| Prescription Medications | Dosage | Reason for Taking Medication |
|---|--------|------------------------------|
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| Non-Prescription Medication <i>(over the counter medication)</i> | Dosage | Reason for Taking Medication |
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OFFICE USE ONLY

| MEDICATION RECONCILIATION | DOSAGE | ROUTE |
|---------------------------|--------|-------|
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IV CONTRAST INJECTION: Date: _____ Time: _____ am _____ pm _____

of attempts _____ Site: _____ left _____ right _____ Aseptic techniques used

Type of device: _____ Gauge: _____ Length: _____

Type of contrast: _____ Amount: _____ Lot#: _____

- A new syringe was used; contrast was bled through the tubing and re-bled prior to injection.
- The injection was monitored and no suggestion of extravasation occurred.
- The used syringe and tubing was dismantled and discarded.

Signature (full name and title of person injecting)

IN THE EVENT OF A MEDICAL EMERGENCY AND TRANSFER A COPY OF THIS FORM WILL ACCOMPANY THE PATENT