NORTH HOLLYWOOD CARDIO-VASCULAR CENTER

Label Here

MEDICATION RECONCILIATION FORM

ALLERGIES	
☐ No Known Drug Allergies	
Drug	**Reaction**
Iodine/Contrast Yes No	
Latex Yes No	

Medication	Dose	Route	Frequency	Review Date / /	Review Date / /	Review Date / /	Review Date / /
				Date/Time of Last Dose ("X" indicates discontinued)			
MD Initials	Initials indicate review of patient medications prior to procedure						
RN Initials							

Print Name	Signature	Initials

If new medications were prescribed, document new medications on this form and provide the patient and the next care provider with a copy.
If no new medications were ordered and the patient has a current medication list, no further action is required.
If patient does not have a medication list, provide them with a copy of this form.

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