Microsurgical Spine Center
OUTPATIENT SURGERY CENTER

LABEL

PATIENT CURRENT ALLERGY AND MEDICATION RECORD

Please list all allergies and known reactions:

ALLERGY	REACTION

Please list **ALL** medications (**prescriptions, over-the-counter, herbal, etc**) in all forms that you are currently taking. Clearly list the names as they appear on the product's packaging.

NAME OF MEDICATION	STRENGTH/ DOSAGE (mg, ml, etc)	FREQUENCY TAKEN (Number, Time/day, week, etc.)	HOW YOU TAKE (Pill, Injection, Cream, etc.)	CHANGES DATE & INITIAL

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I hereby acknowledge that the above list is accurate, complete and represents the medications that I am currently taking as of:

DATE OF SERVICE	PATIENT SIGNATURE	NURSE SIGNATURE

Prescriptions Patient is Discharged With: COMPLETED BY NURSE AT DISCHARGE

DATE	NAME OF MEDICATION	N=NEW R=REFILL	STRENGTH/ DOSAGE (mg, ml, etc)	FREQUENCY TAKEN LAST TAKEN IN ASC (Number, Time/day, week, etc.)	BEGIN NEXT DOSE AT:

COPY GIVEN TO PATIENT AT DISCHARGE & COPY MAINTAINED IN PATIENT CHART