Lansing Surgery Center ☐
1707 Lake Lansing Rd
Lansing MI 48912
Phone: 517-708-3340
Fax: 517-267-0430
www.lansinggenesis.com

PATIENT MEDICATION RECONCILIATION FORM
Please Complete and Mail or Fax - As Soon As Possible

☐ **Genesis Surgery Center**
3400 East Jolly Rd
Lansing MI 48910
Phone: 517-708-3240
Fax: 517-272-1575
www.lansinggenesis.com

Patient Name _____ **Height** _____ **Weight** _____

Please complete this form to help us provide safe patient care. Thank-You.

Patient's Pharmacy _____ **Phone** _____

Medication History Provided By: (Patient, Family, Significant Other) _____

Allergies or Sensitivities	Type of Reaction	Allergies or Sensitivities	Type of Reaction
☐ **No Known Allergies**			
		Latex Allergy: ☐Yes ☐No	

Home Medication on Admission (Prescription/Patches/Inhalers/Eye Drops/Herbals/Over The Counter)

Drug Name	Time/Date Last Dose	Drug Name	Time/Date Last Dose

New Medication Prescribed at Discharge OFFICE USE ONLY

Drug Name	Dose	Route	Frequency

❑ Patient to follow up with primary or prescribing physician regarding all medications and doses.

	1st Review	Date	Subsequent Review	Date
PreOp RN:				
Endo/Surgical RN:				
PostOp RN:				
Physician:				

This list of medications was provided to Lansing Genesis Surgery Center upon admission by Patient/Family/Significant Other.

❑ If checked, per your physician's request, please avoid aspirin or aspirin like products (including Nuprin, Ibuprophen, Motrin, Advil, Aleve) or other non-steroidal anti-inflamatory drugs for _____ after the procedure. May take Tylenol if needed.

_____
PATIENT/RESPONSIBLE PARTY

Patient Label

White - Office Canary - Patient