SouthSound RADIOLOGY

Medication Reconciliation Form

Patient: ___________________________________ MRN: ______________ Completed by: _____________

Exam: ____________________ **Exam Date**: ___________ ☐ **MALE** ☐ **FEMALE** **AGE:** ______

WEIGHT________ **HEIGHT** ________ ANXIETY LEVEL _______ 1-10 (10 **being greater**)

Please list all medications you are ***presently*** taking. (Specifically for sleep/pain/anxiety)

Name of Medication	Last dose taken
1.	
2.	
3.	
4.	
5.	
6.	

ALLERGIES:

Type	Description
1.	
2.	
3.	

INFORMED CONSENT FOR SEDATION

1) I am advised not to drive a car or operate any mechanical devices until not impaired (at least six hrs.) following the procedure.
2) I am advised not to drink alcoholic beverages until not impaired (at least six hrs.) following the procedure.
3) I am advised not to sign any legal documents until not impaired (at least six hrs.) following the procedure.

Patient Signature: ____ Date: ______________________

Witness Signature: __________________________________ Date: _______________Time:_________

PATIENT SEDATION NEEDED

0.25 mg Xanax 0.5 mg

LB JB DM SL TL TP KR NS DS AT IT EV JF CS RM MI ROS

Revised 7/09