SHAREDID-11

Gastroenterology Associates - Endo Medication List

Patient: ______________________ Phone: ____________

DOB: ______________________ Age: ____________ Cell: ______________

Referring Dr. ____________________ Date: ____________ Attd: ____________

Allergies: ____________________

Date of Procedure: ____________

PLEASE LIST ALL MEDICATIONS, DOSAGE AND FREQUENCY TAKEN

Prescription Medications:

NAME	DOSE	FREQUENCY	LAST DATE TAKEN

Over the Counter Medications:

NAME	DOSE	FREQUENCY	LAST DATE TAKEN

MEDICATION RECONCILIATION (Endo Center Use)

_____ Continue Home Regimen ____________________

_____ Stop Taking ____________________

_____ Hold ____________________

_____ Begin Taking ____________________

_____ R.N. ____________________

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