DOCTORS HOSPITAL OF MANTECA

137

137 DHM 12/2019

MEDICATION LIST – PRE-SURGICAL SCREENING SERVICE

Name:_____ **Birth date:**_____

Primary Care Physician: _____ **Pharmacy**_____
Name Location

Allergies to medication, food, latex, tape, other: ☐ No ☐ Yes
Please list the item and the type of reaction experienced: _____

Current Prescription Medications & Over-the-counter Supplements: Example: Aspirin, vitamins, weight-loss products. ** Print exactly as written on the bottle. Cannot accept attached list**

Name of Medication	Dose (mg/ml)	Route (by mouth)	How Many	How Often (2 x day as needed)	Reason for Use	Time Taken (7am / 9pm)	Hospital Use only

Your "Final Active Medication List" will be given to you at discharge.

MEDICATION LIST – PRE-SURGICAL SCREENING SERVICE

*«PatientNumbe

«PatientName» «BirthDate»
ACCT# «PatientNumber» «AdmitDate» «AdmitTime»
«AdmittingDoctorName» MR:«MedicalRecordNumber» «Gender» «Age»
DHM HSV:«HospitalService» FC:«FinClass» PT:«PatientType»