Royal Victoria Regional Health Centre

www.rvh.on.ca

PRE-SURGERY MEDICATION REVIEW

PATIENT NAME: _____

DOB: _____

HRN: _____

(addressograph)

TO THE PATIENT: Please complete as much of the information below as possible

Community Pharmacy(s): _____ Tel. # _____

_____ Tel. # _____

Height: _____ cm _____ inches Weight: _____ kg _____ lbs

ALLERGIES

(eg. hives, rash, swelling, difficulties breathing)

Agent (eg. drugs, foods)	Type of reaction?	Age at occurrence

INTOLERANCES

(eg. nausea, upset stomach, dizziness, hallucinations)

Agent (eg. drugs, foods)	Comments

Pre-Surgery:
Nurse Employee #: _____ Nurse Signature: _____ Date: _____

Surgery-Preparation:
Nurse Employee #: _____ Nurse Signature: _____ Date: _____

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PATIENT NAME: _____

DOB: _____

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MEDICATIONS TAKEN BY PATIENT

*(please fill out as completely as possible - **NOT SHADED AREAS**)*

Pt. to Bring Own (✓)	Pt. to ask about holding preop (✓)	Name of Drug	Dose	Directions	Date/Time Last Dose Taken

NON-PRESCRIPTION MEDICATIONS

(eg. herbals, OTC, vitamins & minerals, recreational)

Pt. to ask about holding preop (✓)	Name of Drug	Dose	Directions	Date/Time Last Dose Taken