Northern Baltimore
SURGERY CENTER

Medication List

Patient Label

Please complete the Medication Section including any over-the-counter medications, vitamins, or herbal supplements.

Patient Name: ______________________________ Date of Birth: ______________

Daytime Phone Numbers: (Home) ______________ (Cell) ______________ (Work) ______________

E-mail Address ______________________________

Person taking you home: ______________________________ Phone Number: ______________

MEDICATIONS: **PHYSICIAN ORDER SECTION:**

MEDICATION NAME	DOSE	FREQUENCY (HOW OFTEN)	LAST DOSE	CONTINUE	CHANGES/SPECIAL INSTRUCTIONS
				Yes No	
				Yes No	
				Yes No	
				Yes No	
				Yes No	
				Yes No	
				Yes No	
				Yes No	
				Yes No	
				Yes No	
				Yes No	

Please list any additional medications on the back of this sheet ⟶

ALLERGIES:______________________________

NEW DISCHARGE MEDICATION ORDERS:

MEDICATION NAME	DIRECTIONS	NEXT DOSE
DROPS	ONE DROP_______TIMES A DAY TO OPERATIVE EYE	
DROPS	ONE DROP_______TIMES A DAY TO OPERATIVE EYE	
DROPS	ONE DROP_______TIMES A DAY TO OPERATIVE EYE	
DROPS	ONE DROP_______TIMES A DAY TO OPERATIVE EYE	

______________________________ MD Verifying RN:______________________________

______________________________ ❑ Copy given to Patient

Patient/Significant Other Signature