JEFFERSON AMBULATORY SURGERY CENTER
PAIN MANAGEMENT MEDICATION FORM

Patient Label

Please include all prescriptions, over-the-counter, vitamins and herbal / natural medications taken routinely prior to admission.

Data Source: ☐ Patient ☐ Family ☐ MD ☐ Pharmacies ☐ Old Records ☐ Other Healthcare Facility

Allergies: _____

Name of Medication	Dosages	Frequency and Route	Indication (Why taking meds)	Prescriber	Medication Taken date:	Medication Taken date:	Medication Taken date:	Medication Taken date:

Patient Signature: _____ Nurse Signature: _____ Date: _____

Patient Signature: _____ Nurse Signature: _____ Date: _____