

Patient label

Home Medication List

This list of medications will assist us in preparing you for your procedure.
Following the procedure this list will serve as your new medication list.

Please fill out this form completely and bring this form with you the day of your procedure.

Include all prescriptions, over-the-counter, herbals, & vitamins/supplements.

Your pharmacy or primary physician can help you if needed.

Medication Name	Dose (mg,units)	Frequency	Last Dose (date/time)	MD use only	MD use only	MD use only
				Continue	Hold	Stop
				<input type="checkbox"/>	<input type="checkbox"/> ___ days	<input type="checkbox"/>
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				<input type="checkbox"/>	<input type="checkbox"/> ___ days	<input type="checkbox"/>

New Medications (following procedure)	Dose	Frequency	Special Instructions

Physician Signature

Discharge Nurse

MIDWEST ENDOSCOPY SERVICES, LLC
8901 Indian Hills Drive, Suite 100
Omaha, NE 68114 (402)933-1500

Office use only
<input type="checkbox"/> No medications taken at home
<input type="checkbox"/> Incomplete medication list
Reason _____
Medication information obtained from:
<input type="checkbox"/> Patient <input type="checkbox"/> Caregiver <input type="checkbox"/> Medication List
<input type="checkbox"/> Brought Medications from home
_____ Admitting Nurse

Original facility copy ♦ Yellow patient copy
Copies to be sent to referring MD office and Endoscopist office