PATIENT MEDICATION AND ADMISSION INFORMATION FORM

PLEASE FILL OUT AND BRING THIS FORM WITH YOU ON THE DAY OF YOUR PROCEDURE.

Patient Name:_____ **Date of Birth:**_____ **Height:**_____ **Weight:**_____

Procedure Date:_____ **MD (circle): Tamimi, Collier, Bigornia, Glazier, Mirchandani, Menadier**

Primary Care MD /Referring MD/ or Surgeon:_____

Who is driving you home from the procedure?
Ride / Transportation Name:_____ **Phone #:**_____

Emergency Contact: Name:_____ **Relationship:**_____ **Phone #:**_____

Do you have a living will or Advanced Directive?_____ **If yes did you bring a copy?**_____

It is important for your physicians to have an **up to date record of all the medication you take. Please use this form to list all the medications you take on a regular basis** (including herbals, over the counter medications and vitamins). Copy the information from the medication container, including the dose and how often you take it (example: 50mg 4x/day). **DO NOT BRING THE MEDICATION WITH YOU.**

Pharmacy Name & Phone Number:_____

FOOD ALLERGIES:_____

MEDICATION ALLERGIES:_____

CURRENT MEDICATIONS Including regularly taken OTC, Herbals, etc.)	Dose	Frequency	Last dose taken: Date/time

Continue on reverse as needed