



Medications	Dosage	Frequency	Last Taken

Patient's Signature: \_\_\_\_\_  
Date: \_\_\_\_\_ Time: \_\_\_\_\_

Signature of RN obtaining original list of medications: \_\_\_\_\_  
Date: \_\_\_\_\_ Time: \_\_\_\_\_

Post-Op Medication Orders: (Physician is to complete this section)  
\_\_\_\_\_  
 No Change. Take all medications as listed on admission  
 Change: \_\_\_\_\_  
 Discontinue: \_\_\_\_\_  
Physician Signature: \_\_\_\_\_  
Date: \_\_\_\_\_ Time: \_\_\_\_\_