Texas Orthopedic Hospital
Patient's Current Medication(s)

Home medications authorized by your physician to be continued while you are a patient at Texas Orthopedic Hospital, **will be provided by Texas Orthopedic Hospital Pharmacy Department**. It's very important that you provide us with a complete record of all the medication(s) you are currently taking. Medications include prescriptions, non-prescriptions (over the counter drugs), vitamins and herbal supplements (or alternative medications).

Please complete this form accurately and legibly(typed or printed in ink). Please feel free to ask any questions regarding your medications and /or if you require additional space.

ALLERGIES:____

Medication Name **Example: Colace**	**Strength** **100mg**	**Dose** **How many and how taken** **1 capsule**	**Frequency** **How often and what time do you take the medication(s)?** **Twice daily**	**Date Last dose taken** **1/21/11**

Pharmacy:___________________________ Address:________________________________ Phone:____________

This list is a complete and accurate list of the medicines that I take on a routine basis.

I understand that I may bring my own home medicines in their *original* container, **only in the event that my prescribed medication is not on the Hospital Formulary** and only if my treating doctor at the Hospital has written an order for me to do so. If I am admitted to the Hospital, I will be required to give my medication(s) to my nurse to identify, secure and administer to me at the appropriate time(s).

While I am a patient at Texas Orthopedic Hospital, I agree not to take any medicine, including medicine for pain that is not prescribed to me by my treating doctor at the Hospital and administered to me by a nurse. If I take any medicine that is not prescribed to me by my treating physician at the Hospital, I understand that a severe drug-to-drug interaction, including life threatening side effects, may occur and could negatively affect my recovery.

____ ____________________
Patient or Patient's Legal Representative Signature Date

Print Name:____

Relationship to Patient if Patient's Legal Representative:_______________________________

Witness Signature:_____________________________________

Print Witness Name:____________________________________

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PATIENT CURRENT MEDICATION