Preoperative Medication Administration Checklist

Patient Name:

Medical Record #:

Date of Surgery:

Surgery Type:

Surgeon:

Operating Room #:

Medication Name	Dosage	Route	Time Administered	Administered by (Initials)	Checked by (Initials)

Allergies:

Special Instructions:

Nurse Signature:

Date/Time:

Verifier Signature:

Date/Time: