Pre-operative Medication Prescription Form

Patient Information

Name

Patient ID / MRN

Date of Birth

Age

Gender

Procedure

Date of Surgery

Time of Surgery

Allergies

Specify any known drug or other allergies

Pre-operative Medications

Medication Name	Dosage	Route	Frequency	Timing before Surgery	Remarks

Special Instructions

Enter any special instructions

Prescribed By

Name

Date

Signature