SPINE PREHAB

MEDICATION LIST

Please complete and bring with you to the hospital

Name: ______________________ Date of Birth: ______________________

Allergies: ____

Pharmacy: ______________________ Pharmacy Phone: ______________________

PRESCRIPTION Medication (eye drops, patches, inhalers, pumps)	Dosage (ex. 20 mg tablet)	How often you take? (ex. three times a day)	Last dosage taken?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

OVER THE COUNTER Medication (supplements, herbals)	Dosage (ex. 20 mg tablet)	How often you take? (ex. three times a day)	Last dosage taken?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

PLEASE DO NOT BRING YOUR MEDICATIONS TO THE HOSPITAL. PLEASE BRING THIS LIST WITH YOU.

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Spine Prehab is currently under review for Service Mark by the Department of Neurosurgery

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