Patient Label

Please list all medications, including over-the-counter medications.
Bring all of these with you when you come for your procedure.

Name of Medicine	Dosage	How Often	Prescribed by	Last Dose Taken	Physician Use Only Continue Med in RCC/Home	
					Yes	No

I am allergic to the following medications:_____

_____

_____

_____
Patient Signature/Date

I have acknowledged and reviewed the list of medications the patient has provided to me today.

_____
Nurse Signature/Date

_____
Physician's Signature/Date