VASCULAR INTERVENTIONAL SPECIALISTS | CORA

NAME: _____

Place sticker if available

DOB: _____ AGE: _____

MEDICATION LIST

Please check location:

SCHC RADIOLOGY ☐ BEND ☐ RDMD ☐ PV ☐ MADRAS ☐ **CMI** ☐ **HEART CENTER**

PATIENT or RESPONSIBLE PARTY TO COMPLETE:

Do you have any DRUG and/or CONTRAST Allergies? ☐ Yes ☐ No

If you answered YES, please list the DRUG and REACTION: _____

PATIENT or RESPONSIBLE PARTY TO COMPLETE:

List all current medication (or HELD for this procedure) including vitamins and herbal supplements

EXAMPLE: Medication, Dose, Route > Lasix 10mg oral

Medication	Dose	Route

Patient Signature or Responsible Party Signature: _____