



RHODE ISLAND MEDICAL IMAGING

*****Please fill this out and bring it with you to your appointment*****

MEDICATION LIST FOR IMAGING GUIDED BREAST PROCEDURE

Patient name (please print): _____

Please list all allergies: _____

WITHIN THE LAST WEEK HAVE YOU TAKEN ANY OF THE FOLLOWING MEDICATIONS?

1. Any medication to thin your blood? YES NO
(This could include: Heparin, Lovenox, Coumadin, Plavix, Ticlid, and others)

If Yes, Please complete a listing below:

Medication	Dose	Date and time of last dose

Aside from above, please identify any and all current medications you have taken in the last week by listing them below:

Medication	Dose	Date and time of last dose

Patient's signature: _____ **Date:** _____ **Time:** _____
(Patient or person authorized to consent for patient)

FOR OFFICE USE ONLY. DO NOT WRITE BELOW THIS LINE.

I have reviewed the above list of current Medications with the patient prior to the procedure.

Date: _____ **Time:** _____

Physician's name: _____

Physician's signature: _____