INTRODUCTION
Medication reconciliation is the formal process of obtaining the Best Possible Medication History of all the medications the patient is currently taking and comparing it with the prescribed medication list at patient admission, transfer or discharge. The goal is to avoid unintentional discrepancies, thus promoting medication compliance and preventing medication-related problems in transitions of care.

OBJECTIVE
Assess the impact of the pharmaceutical intervention in the medication reconciliation at the admission of patients with programmed surgery, in a surgical pre-hospitalization clinic.

MATERIALS AND METHODS
Prospective observational study conducted between September 2021 and July 2022. The collection of the medication list is carried out by the nurse. The pharmacist compares the list obtained with the prescription made during hospitalization and analyzes the discrepancies found (Figure 1). Whenever possible, polymedications selected were patient.

The procedure is summarized in the following diagram (Figure 2).

RESULTS
In total, 654 patients were included and 1115 reconciliation records were made during the study period. The main reconciliation errors found were omission of medication and modification of dose, frequency, route and posology. The main results of this study are represented in the graphs below.

CONCLUSION
Therapeutic reconciliation is an important challenge for health care, being essential to ensure safer care. The integration of the hospital pharmacist in the multidisciplinary team, due to their technical/scientific knowledge and their role in the drug circuit, enables the prevention and detection of medication related problems, contributing to the optimization of therapy. Despite the low acceptance rate, it is considered that the impact of the pharmaceutical intervention was relevant due to the importance of the changes made. There is, however, high scope for improvement. This study identified some limitations of the process, such as the difficulty in contacting the prescriber and the limitation of resources, which does not allow the pharmacist to collect the medication list.

BIBLIOGRAPHY

In total, 654 patients were included and 1115 reconciliation records were made during the study period. The main reconciliation errors found were omission of medication and modification of dose, frequency, route and posology. The main results of this study are represented in the graphs below.