



Person's Name (First / MI / Last):			Record #:
Medications Ordered By Other Health Care Providers Not by above HCP			
Medications	Dose	Frequency	HCP

Health Care Provider Orders											
Allergies: <input type="checkbox"/> NKA						HCP Name:					
D/C	Medication	Dose	Quantity Dispensed	Frequency	Route	Treatment Purpose (Include specific symptoms for PRN's)	Special Instructions (Include any vital signs monitoring and parameters needed.)	# hrs late med may be given, with min. 3 hrs between doses	Scripts Given	P	V
										<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>

HCP Write New Medication Orders Today Here <input type="checkbox"/> None Prescribed									
Medication	Dose	Frequency	Route	Special Instructions (Include treatment purpose and PRN symptoms/parameters)			# hrs late med may be given, with min. 3 hrs between doses	P	V
								<input type="checkbox"/>	<input type="checkbox"/>
								<input type="checkbox"/>	<input type="checkbox"/>
								<input type="checkbox"/>	<input type="checkbox"/>
								<input type="checkbox"/>	<input type="checkbox"/>

All Information and medication noted above has been reviewed and the Health Care Provider has completed the shaded areas.

Prescriber (Print Name)	Prescriber Signature & Credentials	Date:
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Posted by: Time/Date: Verified by: Time/Date: Computer updated by:

Date of Service	Provider Number	Loc. Code	Prcdr. Code	Mod 1	Mod 2	Mod 3	Mod 4	Start Time	Stop Time	Total Time	Diagnostic Code