

PRESCRIBER'S DIGIORDER

FACILITY & FLOOR/WING		ROOM NO.	DATE OF BIRTH	HEALTH CARD NO.
RESIDENT		ALLERGIES		PRESCRIBER

TC-33452.050 MEDCF-POF-802-214-20250113

DATE:	TIME:	INDICATION(S):		PROCESSED BY (or 1st check)	CHECKED BY (or 2nd check)			
				Signature	Signature			
				Date/Time	Date/Time			
		INDICATION(S)		PLEASE INITIAL AS PERFORMED				
				Transcribed to MAR/TAR	DRB	Diet	Lab / X-Ray	Appt
				Progress Notes	Care Plan Infection Control			
DELIVERY OPTIONS: <input type="checkbox"/> Regular Delivery <input type="checkbox"/> Next Weekly Strip Delivery (Default will be Next Weekly Strip Delivery unless otherwise specified)		Prescriber's Signature	Licence No.	<input type="checkbox"/> Notified POA/Resident Signature & Date				
		Unless otherwise indicated, the prescriber signature provides authorization for the pre-printed prescription quantities, up to such time as the order may be discontinued	Date/Time (for co-signature)					

ISMP DO NOT USE: U, IU, CC, OS, OD, OU, QD, D/C, QOD, µg, @, >, <, trailing zeros, or drug name abbreviations. Always use zero before decimal point (0.XXmg).

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If prescriber authorization is pending receipt by the pharmacy, to ensure continuity of care, I authorize an additional 4 refills of all active, prescribed medications.

DO NOT WRITE ON ANY MARGIN