

NEW ADMISSION ORDER FORM

Please complete all fields

☐ New admission

☐ Re-admission

☐ Please send new MAR

FACILITY	WARD/WING	ROOM/BED	PRESCRIBER	HEALTH CARD NO.
RESIDENT	ALLERGIES			

Date: _____

Please fill out below medication list for all NEW admissions and RE-admissions:

COMPLETE MEDICATION LIST	ON ADMISSION			COMPLETE MEDICATION LIST	ON ADMISSION		
Medication Order and Directions	Continue	Discontinue	Hold	Medication Order and Directions	Continue	Discontinue	Hold
Indication: Last Dose Given: Source code: <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Indication: Last Dose Given: Source code: <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Regular medication

Strip Scheduled: 7 day supply. Repeat x 60

PRN: 30 units. Repeat x 60

Non-repackaged: manufacturer's pack size. Repeat x 30

Topical bulk: 7 day supply. Repeat x 60

Benzodiazepines:

Scheduled: 7 day supply. Repeat x 60

PRN: 30 units. Repeat x 60

All prescriptions expire one year from the date of issue

Controlled and Narcotics:

Scheduled: 1000 (one thousand) units. Dispense 7 day

supply every 7 days; Patches 100 (one hundred) units. Dispense 5 patches every 12 days

PRN: 1000 (one thousand) units. Dispense 30 tab / 100 mL every 3 days as needed

Source of Medication Information

- ☐ 1. Resident Medication List
☐ 2. CCAC
☐ 3. Discharge List from Hospital / Specialist
☐ 4. Review of Resident Medication Vials
☐ 5. Community Pharmacy List
☐ 6. MAR from another facility
☐ 7. Patient/Family recall
☐ 8. Other _____

Lab Work / Diet / Other Orders:

☐ **Oseltamivir Phosphate** Directions - IN CASE OF AN INFLUENZA OUTBREAK, GIVE 1 CAPSULE P.O. DAILY UNTIL OUTBREAK DECLARED OVER FOR PROPHYLAXIS LU:371 PHARMACIST TO ADJUST DOSE AS PER RENAL FUNCTION

Phone Order ☐ Prescriber: _____ Licence No.: _____
 Taken By: _____ Date/Time: _____

Prescriber's Signature: _____ Licence No.: _____
 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

Nurse #1 Signature: _____ Date: _____ Nurse #2 Signature: _____ Date: _____

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