

# 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"/>
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"/>
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"/>
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"/>

Regular medication	Benzodiazepines:	Controlled and Narcotics:
<b>Strip Scheduled:</b> 7 day supply. Repeat x 60 <b>PRN:</b> 30 units. Repeat x 60 <b>Non-repackaged:</b> manufacturer's pack size. Repeat x 30 <b>Topical bulk:</b> 7 day supply. Repeat x 60	<b>Scheduled:</b> 7 day supply. Repeat x 60 <b>PRN:</b> 30 units. Repeat x 60 All prescriptions expire one year from the date of issue	<b>Scheduled:</b> 1000 (one thousand) units. Dispense 7 day supply every 7 days; Patches 100 (one hundred) units. Dispense 5 patches every 12 days <b>PRN:</b> 1000 (one thousand) units. Dispense 30 tab / 100 mL every 3 days as needed

<b>Source of Medication Information</b> <input type="checkbox"/> 1. Resident Medication List <input type="checkbox"/> 2. CCAC <input type="checkbox"/> 3. Discharge List from Hospital / Specialist <input type="checkbox"/> 4. Review of Resident Medication Vials <input type="checkbox"/> 5. Community Pharmacy List <input type="checkbox"/> 6. MAR from another facility <input type="checkbox"/> 7. Patient/Family recall <input type="checkbox"/> 8. Other _____	<b>Lab Work / Diet / Other Orders:</b> _____ _____ _____ _____ _____ _____
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☐ **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 <input type="checkbox"/> 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
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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

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