



DIGITAL PRESCRIBER'S ORDERS

Facility : _____

Resident : _____

Health Card# : _____

Allergies : _____

Unit : _____

CrCl : _____

DOB (dd/mm/yyyy) _____

Date:		Time	Clinical Indicator			
		<input type="checkbox"/> Start with Next Weekly Supply				
		<input type="checkbox"/> Start Today				
Prescriber's Signature	Nurse 1	Nurse 2	Nurse: Please Initial The Documentation As Performed			
			Care Plan	Consent	Mar/Tar	Lab
Registration#	Date / Time	Date / Time				

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