

PHYSICIAN'S ORDER FORM

USE FOR DIGITAL PEN ONLY



SECOND FLOOR

HOME _____

RESIDENT _____

ROOM# _____

PHYSICIAN _____ ALLERGIES _____

DATE:	TIME:	NURSE 1		NURSE 2		
		SIGNATURE		SIGNATURE		
		DATE/TIME		DATE/TIME		
		PLEASE INITIAL THE DOCUMENTATION AS PERFORMED				
		PHARM FAX/PH	MAR	TAR	DRB	POA
		DIET/LAB/XRAY		DC'd Meds Pulled Direction Change Sticker		
PHYSICIAN SIGNATURE:		REQ		Nurses Signature		

Unless otherwise specified: Duration: Ongoing; Rx Quantity Dispensed: Seven (7) days Rx cycle for regularly scheduled oral pill-form: Narcotic, Bulk Liquid, PRN 30 doses: Bulk Topical 30G; One (1) pack for manufacturer pre-packaged products.

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