

PRESCRIBER'S DIGIORDER

TC:33452.090.MEDOF-POF-S02-214-20200113

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

Please use DigiPen to complete resident and order information, dock the pen and place in chart in preparation for orders.

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.	
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	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)	
<input type="checkbox"/> Notified POA/Resident Signature & Date				

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