



1

PHYSICIAN/PREScriBER PLEASE SIGN AND RETURN

Send NO MEDS Send * MEDS ONLY When available/next routine delivery:
 Send ALL MEDS Doses taken from Emergency/Backup Stock Stat

Telephone Orders

Facility Name			Address			Signature of Nurse Receiving Order		Date/Time	
Family Name		First Name	DOB	Admission Number	Room Number	Attending Physician			
Date Ordered	Time Ordered	Date DC'd	MEDICATION /Order	Dose & Form	Route	Schedule	INDICATION - DX		
Physician/Prescriber Signature			Title	Date	<input type="checkbox"/> Resident <input type="checkbox"/> Family has been notified of the above treatment change. Date notified ____/____/____ Name of person contacted _____ If not contacted, reason _____				
Pharmacy: <input type="checkbox"/> Courier <input type="checkbox"/> Faxed (Fax Original) <input type="checkbox"/> Phone On Physician's Order Sheet Med Sheet TX Sheet Nurse's Notes Patient Care Plan ADL/Flow Signed Date Time									

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