Guardian® pharmacy Atlanta

Phone: 770-635-3301 | Fax: 770-635-3302

Physician Orders

Physician, please provide medication orders for this patient, including complete directions for use, quantity to dispense, and number of authorized refills. *Unless noted otherwise, these orders will be good for six months.* If you are writing more than six orders, you may make additional copies of this form.

Patient Name: _____ **Date of Birth:** _____

Allergies: _____

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1. **Medication & Strength:** _____
   Sig: _____
   Quantity: _____ **Refills:** 1 2 3 4 5 PRN

2. **Medication & Strength:** _____
   Sig: _____
   Quantity: _____ **Refills:** 1 2 3 4 5 PRN

3. **Medication & Strength:** _____
   Sig: _____
   Quantity: _____ **Refills:** 1 2 3 4 5 PRN

4. **Medication & Strength:** _____
   Sig: _____
   Quantity: _____ **Refills:** 1 2 3 4 5 PRN

5. **Medication & Strength:** _____
   Sig: _____
   Quantity: _____ **Refills:** 1 2 3 4 5 PRN

6. **Medication & Strength:** _____
   Sig: _____
   Quantity: _____ **Refills:** 1 2 3 4 5 PRN

_____ **Date :** _____
Physician Signature

_____ **DEA#:** _____
Print Name

Best phone number to reach you for questions: _____