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

☐ Resident ☐ Family has been notified of the above treatment change. Date notified ____/____/____
Name of person contacted _____ If not contacted, reason _____

NURSE: Please Initial The Documentation Record As Performed

Pharmacy	On Physician's Order Sheet	Med Sheet	TX Sheet	Nurse's Notes	Patient Care Plan	ADL/Flow	Signed	Date	Time
☐ Courier ☐ Faxed (Fax Original) ☐ Phone									

2

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

☐ Resident ☐ Family has been notified of the above treatment change. Date notified ____/____/____
Name of person contacted _____ If not contacted, reason _____

NURSE: Please Initial The Documentation Record As Performed

Pharmacy	On Physician's Order Sheet	Med Sheet	TX Sheet	Nurse's Notes	Patient Care Plan	ADL/Flow	Signed	Date	Time
☐ Courier ☐ Faxed (Fax Original) ☐ Phone									

©MED-PASS, Inc.

3

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

☐ Resident ☐ Family has been notified of the above treatment change. Date notified ____/____/____
Name of person contacted _____ If not contacted, reason _____

NURSE: Please Initial The Documentation Record As Performed

Pharmacy	On Physician's Order Sheet	Med Sheet	TX Sheet	Nurse's Notes	Patient Care Plan	ADL/Flow	Signed	Date	Time
☐ Courier ☐ Faxed (Fax Original) ☐ Phone									

©MED-PASS, Inc.