Resident Name _____ Date Completed _____

Date of Birth _____

PRESCRIBER'S MEDICATION AND TREATMENT ORDERS AND OTHER INFORMATION

Allergies (list all): _____

Note: Does resident require medications crushed or in liquid form? Indicate in 12(a) with medication order. If medication is ***not*** to be crushed please indicate.

12(a) Medication(s). Including PRN, OTC, herbal, & dietary supplements. **Include dosage route (p.o., etc.), frequency, duration (if limited).**	**12(b) All related diagnoses, problems, conditions.** **Please include all diagnoses that are currently being treated by this medication.**	**12(c) Treatments (include frequency & any instructions about when to notify the physician).** **Please link diagnosis, condition or problem as noted in prior sections.**	**12(d) Related testing or monitoring.** **Include frequency & any instructions to notify physician.**

Prescriber's Signature _____ Date _____

Office Address _____ Phone _____