PHYSICIAN'S MEDICATION AND TREATMENT ORDERS

Instructions:

After this form is completed, it must be signed by the prescriber.
Orders for controlled substances must be accompanied by an original prescription.

Resident Name: _____ Date of Birth: _____

Allergies: _____

Medication	Strength	Dose	Frequency	Route	Diagnosis

I hereby certify these orders are active for 90 days.

Prescriber Signature: _____ Date: _____

Print Name:_____ DEA#: _____
Address:_____
_____
Phone: _____