PHYSICIAN TELEPHONE/VERBAL ORDERS

Patient Name:_____MR #: _____

Physician Name: _____

Medication Order:

Medication Name: _____

Dosage: _____

Strength:_____

Frequency:_____

Intake Route:_____

Medication Name: _____

Dosage: _____

Strength:_____

Frequency:_____

Intake Route:_____

Other Orders:

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Nurse/Therapist Date

_____ _____

Signature of Physician Confirming Orders Date

All orders must be signed by physician within 21 days.