

# PHYSICIAN ADMISSION & DISCHARGE MEDICATION ORDERS

<b>Allergies</b> <input type="checkbox"/> Food <input type="checkbox"/> Iodine <input type="checkbox"/> Contrast media <input type="checkbox"/> Adhesive tape <input type="checkbox"/> Latex <input type="checkbox"/> Shellfish	Height	Weight
	kg	
<b>**Keep this form with Physician Orders**</b>		

ADDRESSOGRAPH

Disposition of patient's medications upon admission:  Medications brought to hospital sent home  Medications not brought to hospital

Data Source:  Patient  Family  Other

"Home" Prescription & Over the Counter Medications							Discharge Medications		
Order			Product Name (List only those meds currently being taken)	Dose (mg, ml, number, gms)	Frequency	Route or Topical Site	Date & Time of Last Dose	Resume at same dose	DO NOT Resume at Discharge to Home
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Already ordered						<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Already ordered						<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Already ordered						<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Already ordered						<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Already ordered						<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Already ordered						<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Already ordered						<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Already ordered						<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Already ordered						<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Already ordered						<input type="checkbox"/>	<input type="checkbox"/>

Herbal Products NOT TO BE TAKEN IN HOSPITAL (Herbals will <u>not</u> be dispensed by KH Dayton Pharmacy)							Discharge Disposition	
							<input type="checkbox"/> Home	
							<input type="checkbox"/> Home Health Care	
							<input type="checkbox"/> ECF - See ECF packet for med list	
							<input type="checkbox"/> Outpatient therapy	
							<input type="checkbox"/> PT	
							<input type="checkbox"/> OT	
							<input type="checkbox"/> Speech	
							<input type="checkbox"/> Corp	
							<input type="checkbox"/> Other _____	
							<input type="checkbox"/> Other _____	

Date/Time \_\_\_\_\_ RN Obtaining Medication History Signature \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date/Time \_\_\_\_\_ HUC Signature \_\_\_\_\_ Date/Time \_\_\_\_\_

Physician Printed Name \_\_\_\_\_ Date/Time \_\_\_\_\_ RN/LPN Signature \_\_\_\_\_ Date/Time \_\_\_\_\_

ADDITIONAL DISCHARGE MEDICATION ORDERS				
Product Name	Dose	Frequency	Route or Topical Site	Script
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>

Physician Signature \_\_\_\_\_ Date/Time \_\_\_\_\_

Printed Physician Signature \_\_\_\_\_ Date/Time \_\_\_\_\_

F/U Appt:  
 D/C Foley  D/C IV Access  PICC line care @ home  
 Dressing changes or treatments  
 Activities:  Resume usual activity  Limited activity  
 Diet:  Regular  Low fat  Low Sodium  ADA  Other \_\_\_\_\_  
 Other: \_\_\_\_\_