PHYSICIAN ORDERS

10929 US HWY 301 S STE 111 Statesboro, Ga 30458
Fax: 1-877-693-9139 Phone: 1-912-764-7839

Please provide medication orders for this resident. Include complete directions for use, quantities to dispense, and number of refills. Your signature indicates these orders may stand for 6 months unless otherwise noted. Make copies for additional orders.

Resident Name: _____ Date of Birth: _____

Allergies: _____

1. Medication & Strength: _____

Sig: _____ Diagnosis_____

Quantity: _____ Refills: 1 2 3 4 5 6 PRN(one year)

2. Medication & Strength: _____

Sig: _____ Diagnosis_____

Quantity: _____ Refills: 1 2 3 4 5 6 PRN(one year)

3. Medication & Strength: _____

Sig: _____ Diagnosis_____

Quantity: _____ Refills: 1 2 3 4 5 6 PRN(one year)

4. Medication & Strength: _____

Sig: _____ Diagnosis_____

Quantity: _____ Refills: 1 2 3 4 5 6 PRN(one year)

5. Medication & Strength: _____

Sig: _____ Diagnosis_____

Quantity: _____ Refills: 1 2 3 4 5 6 PRN(one year)

6. Medication & Strength: _____

Sig: _____ Diagnosis_____

Quantity: _____ Refills: 1 2 3 4 5 6 PRN(one year)

7. Medication & Strength: _____

Sig: _____ Diagnosis_____

Quantity: _____ Refills: 1 2 3 4 5 6 PRN(one year)

PCP Signature: _____ Date: _____ DEA:_____

Name: Printed: _____ NPI: _____ Phone:_____