

Your
Hospital's
Logo
Here

PHARMACY CLARIFICATION and/or CHANGE OF MEDICATION ORDER

AFTER EACH ORDER IS PROPERLY CHECKED, DETACH DUPLICATE
AND FORWARD TO PHARMACY, WHETHER OR NOT ORDERS INVOLVE MEDICATION

PATIENT IDENTIFICATION	Check (✓) Each Order As Transcribed	Check (✓) Pharmacy Orders	Allergy	
			PHYSICIAN'S ORDER	DATE WRITTEN: _____ TIME WRITTEN: _____
			PHARMACY CLARIFICATION and / or CHANGE OF MEDICATION ORDER	
			PATIENT NAME:	RM #:
			TO DOCTOR:	Rx:
	FAXED BY/TIME:	TIME NOTED:	Doctor's Signature _____, MD Date _____ Nurse's Signature / Title _____ Date _____	

Military Time >>

PATIENT IDENTIFICATION	Check (✓) Each Order As Transcribed	Check (✓) Pharmacy Orders	Allergy	
			PHYSICIAN'S ORDER	DATE WRITTEN: _____ TIME WRITTEN: _____
			PHARMACY CLARIFICATION and / or CHANGE OF MEDICATION ORDER	
			PATIENT NAME:	RM #:
			TO DOCTOR:	Rx:
	FAXED BY/TIME:	TIME NOTED:	Doctor's Signature _____, MD Date _____ Nurse's Signature / Title _____ Date _____	

Military Time >>

USE BALL POINT PEN ONLY - PRESS FIRMLY

PART OF THE MEDICAL RECORD