Fairway MEDICAL

PHYSICIAN ORDERS - HOME/DISCHARGE MEDICATIONS INVENTORY

ALLERGIES:	HT:	WT:

☐ **Consult primary physician today for continuation of home medications.**

***Meds identified by Ident-a-drug by _____Date _____ Time _____**

****NOTE: PLEASE LIST ALL MEDICATIONS BEING TAKEN, INCLUDING PRESCRIPTIONS, NON-PRESCRIPTIONS, HERBAL REMEDIES, VITAMINS, AND SUPPLEMENTS**

PATIENT TO FILL IN THIS AREA			R.N. WILL COMPLETE THIS AREA			FOR M.D. USE ONLY:			
HOME MEDICATIONS									
MEDICATION (** SEE NOTE ABOVE)	REASON FOR MEDICATION	DOSAGE	ROUTE	FREQUENCY	LAST DOSE	CONTINUE IN HOSPITAL		CONTINUE AT HOME	
						YES	NO	YES	NO
						YES	NO	YES	NO
						YES	NO	YES	NO
						YES	NO	YES	NO
						YES	NO	YES	NO
						YES	NO	YES	NO
						YES	NO	YES	NO
						YES	NO	YES	NO
						YES	NO	YES	NO
						YES	NO	YES	NO
						YES	NO	YES	NO
						YES	NO	YES	NO
						YES	NO	YES	NO
						YES	NO	YES	NO
						YES	NO	YES	NO
						YES	NO	YES	NO
						YES	NO	YES	NO
						YES	NO	YES	NO
						YES	NO	YES	NO
						YES	NO	YES	NO
						YES	NO	YES	NO

FILLED OUT BY ☐ PATIENT ☐ NURSE REVIEWED BY NURSE:	DATE	TIME	ASPIRIN ☐ YES ☐ NO
PHYSICIANS SIGNATURE	DATE	TIME	

ac - before meals **PRN - as needed** **QID - four times a day**
p̄c - after meals **TID - three times a day** **HS - bedtime**
BID - twice a day