FIRST at Blue Ridge, Inc.

PHYSICIAN ORDERS

Client: ________________________ ________________________ ________

Last Name First Name Middle Initial

Allergies (Food, Drugs, Etc.):

PRESCRIBED MEDICATION: List **ALL** medication prescribed by Medical Professionals **INCLUDING ALL OVER THE COUNTER ITEMS.** Sample Medications should be dated & marked by Physician.

Clients **MUST** have a 30 day supply and **AT LEAST** a 90 day refill in order to gain acceptance into our program.

Date	Medication Name	Strength	Administration Directions	Quantity	# of Refills

________________________________ ________________________________

Physician Signature Physician Print

☆ Even if not on prescription medications ALL forms must be signed. ☆