FIRST at Blue Ridge, Inc.
PHYSICIAN ORDERS

Client: ______________________ ______________________ ______________
Last Name First Name Middle Initial

DOB:
ALLERGIES:

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

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

Date	Medication Name	Strength	Administration Directions (Please include route)	Quantity	# of Refills

Even if not on prescription medications, **ALL** forms must be signed.
PLEASE INCLUDE CREDENTIALS.

Qualified Provider (MD, DO, NP, PA) SIGNATURE ______________________________

Qualified Provider (MD, DO, NP, PA) PRINT ______________________________

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