THE COTTAGES

MEDICATION ORDERS: Refillable for 12 months unless otherwise noted.

Resident's Name: _____ Physician's Name: _____Date:_____

Drug/Name	Dosage	Route/Frequency	May Have @ Bedside	Start Date	Discontinue Date
PRN Medications **If symptoms continue for 48 hours MD will be notified**					
Acetaminophen 325 mg	**2 tabs**	**PO Q 4 hrs for pain or fever**			
Antacid	**30cc**	**PO QID GI upset**			
MOM	**30cc**	**PO QD for constipation**			
Imodium AD	**1 cap**	**PO Q 4 hours for loose stool**			
Triple Antibiotic ointment		**According to product instructions**			

Diet Order please circle one:
REG NO ADDED SODIUM NCS

Incontinent Supplies

Other Orders: Home Health/Therapies/Labs/Treatments/Etc:

Resident is appropriate for assisted living

Drug Allergies

I feel that this resident/patient □ **YES is capable** □ **NO is not capable of safely**
Managing his/her own medications

I feel that this resident/patient □ **YES is capable** □ **NO is not capable of safely**
Managing his/her own bedside ordered medications

Can this resident have FLU Vaccine? □ **YES** □ **NO**
Is this resident free of communicable disease(s)? □ **YES** □ **NO**

Physician's Signature: **Date:**

Please Print Physician's Name: _____