VDSS MODEL FORM - ALF

DOCUMENTATION OF PHYSICIAN'S ORAL ORDER FOR PRN (*AS NEEDED*) MEDICATION

NAME OF RESIDENT: _____

NAME OF RESIDENT'S PHYSICIAN GIVING ORDER: _____

DATE OF ORDER: _____

NAME AND STRENGTH OF MEDICATION: _____

PHYSICIAN'S INSTRUCTIONS:

1. **SYMPTOMS THAT MIGHT INDICATE USE OF THE MEDICATION:** _____

   _____

   _____

   _____

2. **MEDICATION DOSAGE:** _____

   _____

3. **TIME FRAMES THE MEDICATION IS TO BE GIVEN IN A 24-HOUR PERIOD:** _____

   _____

   _____

4. **DIRECTIONS IF SYMPTOMS PERSIST:** _____

   _____

   _____

5. **ANY ADDITIONAL INSTRUCTIONS:** _____

   _____

   _____

   _____

NAME OF FACILITY STAFF RECEIVING ORDER:

PRINT: _____

SIGNATURE: _____

032-05-530/1 (Revised 1/02)