ADDRESSOGRAPH AREA

Missouri Baptist Medical Center

BJC HealthCare℠

PHYSICIAN INITIAL MEDICATION ORDERS

Keep this form with Physician Orders

Drug Allergies: _____

Height: _____ Weight: _____ lbs _____kg ☐ Estimate ☐ Actual

Disposition of patient's medications upon admission: Data Source: ☐ Patient ☐ Family ☐ Other

☐ Medications brought to hospital sent home

☐ Medications not brought to hospital

At Home or Outpatient Prescription and Over the Counter Medications

ORDER		PRODUCT NAME (List only those meds currently being taken)	DOSE (mg, ml, number of grams)	FREQUENCY	ROUTE or TOPICAL SITE	DATE and TIME of LAST DOSE
Enter * for clarifi-cation	Check box to continue med					
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Herbal Products (Herbals will **not** be dispensed by MBMC Pharmacy)						

Date / Time _____ Interviewing RN Signature _____

PHYSICIAN INSTRUCTIONS:

1. **Please clarify medication marked with an asterisk (*) in the first column.**
2. **Please check the box in front of each medication to continue during the inpatient stay.**
3. **Please DATE and SIGN the bottom of the form.**

NOTE: If an order to resume/continue home meds is received, the physician will be contacted to verify each of the meds above.

_____ Physician Signature

_____ Date / Time

WHITE - CHART *CANARY - PHARMACY*

same as 1