SAMPLE MEDICATION SHEET

Patient name_____ DOB or chart number_____

Allergy or Rxn to_____ Symptom_____

Allergy or Rxn to_____ Symptom_____

Date	Medication	Dose	Route	Frequency	No	Recall #	Indication	D/C Date

(Once approved and refilled, attach top edge of first request slip on this line)

(Second medication request slip)

(Third medication request slip)

(Fourth medication request slip)

Medication Request Slip

Slips are sized to overlap, exposing only medications and disposition of request(s)

Patient name_____ DOB or chart number_____

Date/time of request___/___/_____AM/PM Pharmacy_____

Patient's MD/PA_____ Phone number_____

	Medication	Dose	Route	Frequency	Quantity	Last fill	Number of fills	Signature for Authorization
1.								
2.								
3.								

Do **NOT** refill #_____ Needs appointment for #_____ Date/time of call___/___/_____AM/PM

Note_____ Initials_____

Source: The Professional Liability Handbook. American Academy of Physician Assistants, 1990.