VDSS MODEL FORM – ALF

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

NAME OF RESIDENT: ____

NAME OF RESIDENT'S PHYSICIAN
OR OTHER PRESCRIBE0R GIVING ORDER: ____

DATE OF ORDER: ___________________________

DIAGNOSIS/CONDITION FOR WHICH THE MEDICATION IS PRESCRIBED: ________________________________

MEDICATION PRESCRIBED:

DRUG NAME: ____

STRENGTH: ____

DOSAGE: ____

ROUTE: ____

PHYSICIAN'S/OTHER PRESCRIBER'S INSTRUCTIONS:

1. **SYMPTOMS THAT INDICATE USE OF THE MEDICATION:** ____

   ____

   ____

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

   ____

3. **DIRECTIONS IF SYMPTOMS PERSIST:** ____

   ____

   ____

4. **ANY ADDITIONAL INSTRUCTIONS, INCLUDING BUT NOT LIMITED TO, INSTRUCTIONS FOR ADVERSE DRUG REACTION & MEDICATION ERROR:**

   ____

   ____

   ____

FACILITY STAFF RECEIVING ORDER:

***PRINT*:** ____ ***SIGNATURE*:** _____________________________________

REVIEW BY PHYSICIAN OR OTHER PRESCRIBER:

***PHYSICIAN'S/OTHER PRESCRIBERS* SIGNATURE:** ____________________________________ **DATE** _________

032-05-0530-02-eng (02/18)