PHYSICIAN'S ORDER

MEDICATIONS	HOUR	ORDERS

SAMPLE

Medication Review

Nurse's Signature | Date | Physician's Signature | Date

CHARTING FOR | THROUGH

Physician | Telephone Number

Alt. Physician | Alt. Telephone Number

Allergies

Diagnosis

Medical Record # | Admission Date | Pharmacist's Signature | Title

Patient	Gender	Date of Birth	Patient Code	Room #	Bed	Facility Code

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