MEDICATION INSTRUCTIONS

A SIGNED LIST OF ALL MEDICATION(s), INCLUDING VITAMINS & SUPPLEMENTS, IS REQUIRED FROM YOUR PHYSICIAN(s).

PLEASE NOTE:

THE MEDICATION CAN BE LISTED EITHER ON THE FORM(s) PROVIDED
OR
PRINTED FROM THEIR COMPUTER AND MUST CONTAIN THE NAME, DOSAGE, REASON, QUANTITIES, DIRECTIONS AND SIGNED AT THE BOTTOM.

IMPORTANT:

ADMISSION TO A COMMUNITY MAY BE DELAYED IF THE MEDICATION LISTS ARE NOT COMPLETED AND/OR CORRECT.

Facility:	Address:
Phone:	Fax:

MEDICATION VERIFICATION

Physician: _____

Your patient, _____, will be a resident of, _____,
a licensed residential care facility for the elderly (RCFE). In order to comply with State regulations, we need your review and verification of your patient's medication orders.

CURRENT MEDICATIONS

The attached is a list of the medications(s) your patient is receiving:

Medication	Dosage	Qty.	Refills	Reason/Diagnosis	Instructions

Physician's Signature_____ **Date:** _____

Physician's NPI #: _____

FACILITY:	ADDRESS:
PHONE:	FAX:

CONTROLLED SUBSTANCE (NARCOTICS) VERIFICATION

Physician: _____

Your patient, _____, will be a resident of, _____, a licensed residential care facility for the elderly (RCFE). In order to comply with State regulations, we need your review and verification of your patient's medication orders.

CURRENT MEDICATIONS

MEDICATION NAME	QTY.	REFILLS	INSTRUCTIONS

Physician's Signature: _____ **Date:** _____

Physician's NPI #: _____