MATRX PHARMACY

PHONE: 360-863-3009 FAX: 360-217-7570

Medications: Please list all prescription drugs and/or over the counter dietary supplements that the resident is currently administering. Please include all routine and PRN medications.

NAME: _____ DOB: _____

ALLERGIES: _____

MEDICATION	DOSE	ROUTE	FREQUENCY	SPECIAL INSTRUCTIONS

I authorize a 30 day supply of all above medications unless otherwise indicated.

_____ _____

Substitution Permitted Dispense as Written

Physician's Printed Name: _____

Date: _____ Phone: _____