CALL 360.863.3009 FAX 360.217.7570

PHYSICIAN ORDERS

DATE_____

Medications: Please list all prescription drugs, OTC medications, and dietary supplements.

NAME: _____ **DOB:** _____

ALLERGIES: _____

MEDICATION	DOSE	ROUTE	FREQUENCY	SPECIAL INSTRUCTIONS

Provider Signature_____ Date_____

Provider Printed Name: _____ Phone:_____