Weight: _____ **kg**
❑ Estimate ❑ Actual

Height: _____ **cm**
❑ Estimate ❑ Actual

_____ **HEALTH REGION**

PREADMISSION MEDICATION LIST / PRESCRIBER ORDER FORM

Keep this form with the Prescriber Orders - Must not be thinned from patient chart.

Allergy/Intolerance Information
❑ Allergy/intolerance information reviewed with patient/designate and recorded below
- If not, state reason: _____

❑ No known allergies/intolerances
❑ Refer to regional allergy/intolerance document, as per regional policy

Drug Allergies	Non-Drug Allergies
Drug Intolerances	**Non-Drug Intolerances**

List of Unacceptable/Acceptable Abbreviations for Prescribing

DO NOT USE	USE THIS	DO NOT USE	USE THIS	DO NOT USE	USE THIS
OD, QD or qd	daily	U, IU, u	unit	> or <	greater than or less than
D/C	discharge or discontinue	cc	mL	trailing zero (x.0 mg)	Never use zero by itself after a decimal
QOD or qod	every other day	µg	mcg	lack of leading zero (.x mg)	Always use a zero before a decimal point if amount less than one
drug name abbreviations	write generic drug name	@	at	OS, OD, OU	left eye, right eye, both eyes

List all prescription, over-the-counter, and herbal medications the patient is taking on the next page. Review each medication with patient/designate to ensure completeness.

More complete PIP information is available via the PIP website (GUI) and the EHR Viewer.

Source of Medication List (check all that apply)
❑ Patient / Family ❑ MAR from other facility ❑ Medication vials or list ❑ Pharmacy _____ ❑ Other _____

Disposition of Patient's Medication on Admission:
❑ Locked up in Nursing Unit ❑ Sent home with: _____ ❑ Not brought to hospital

Medication list begins on next page

_____ HEALTH REGION

CONFIDENTIALITY NOTICE: The content of this communication is confidential and contains personal health information. It is intended solely for the use of the patient's health care providers. **If you have received this communication in error, please notify the sender immediately** and destroy all originals and copies of the misdirected communication.

PREADMISSION MEDICATION LIST / PRESCRIBER ORDER FORM

Keep this form with the Prescriber Orders - Must not be thinned from patient chart.

List all additional prescription, over-the-counter, and herbal medications the patient is taking below. Upon completion, cross out any empty lines to prevent additions. Select the appropriate checkbox at the bottom of table when finished the page. If you require more space, photo-copy this page as many times as necessary **AND** manually update page numbers on **ALL** pages of form as necessary (when form fully complete).

Medication Name ☐ No Preadmission Medications	Dose	Route	Frequency	Time/Date of Last Dose	**Prescriber Orders** Continue	Change	STOP	Comments/Rationale
	Comments							
	Comments							
	Comments							
	Comments							
	Comments							
	Comments							

☐ **End of medication list** **OR** ☐ **Medication list continues on next page.**

Comments / Concerns / Follow-up:

Completed by: Signature Title **Date:** **Time:**

Reviewed by: Signature Title **Date:** **Time:**

Prescriber:

_____ **(print)**

_____ **(sign)**

Date:_____ **Time:** _____

Form Communication: *Initial beside action(s) completed.*
Processed _____ Faxed _____ MAR _____

_____ **HEALTH REGION**

PREADMISSION MEDICATION LIST / PRESCRIBER ORDER FORM

Keep this form with the Prescriber Orders - Must not be thinned from patient chart.

List all additional prescription, over-the-counter, and herbal medications the patient is taking below. Upon completion, cross out any empty lines to prevent additions. Select the appropriate checkbox at the bottom of table when finished the page. If you require more space, photo-copy this page as many times as necessary **AND** manually update page numbers on **ALL** pages of form as necessary (when form fully complete).

Medication Name ☐ No Preadmission Medications	Dose	Route	Frequency	Time/Date of Last Dose	**Prescriber Orders** Continue	Change	**STOP**	Comments/Rationale
	Comments							
	Comments							
	Comments							
	Comments							
	Comments							
	Comments							

☐ **End of medication list** **OR** ☐ **Medication list continues on next page.**

Comments / Concerns / Follow-up:

Completed by: Signature Title **Date:** **Time:**

Reviewed by: Signature Title **Date:** **Time:**

Prescriber:

_____ **(print)**

_____ **(sign)**

Date:_____ **Time:** _____

Form Communication: *Initial beside action(s) completed.*
Processed _____ Faxed _____ MAR _____