PIPTEST, JJ
2316 MONTREAL ST
REGINA, Saskatchewan
S0H 3E0
HSN: 210 123 109

Weight: ________ **kg**
❑ Estimate ❑ Actual

Height: ________ **cm**
❑ Estimate ❑ Actual

____________________ **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.

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**

SAMPLE

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**

On the next page is a PIP generated 4 month medication list, including most recent dispensing date as of **2016-Apr-27.** This list may not be all inclusive. Therefore, list all additional prescription, over-the-counter, and herbal medications the patient is taking. Review each medication with patient/designate to ensure completeness.

NOTE: Dose and frequency ARE NOT provided on this medication list.
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

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PREADMISSION MEDICATION LIST / PRESCRIBER ORDER FORM

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Medication Name	Dose	Route	Interval	Time / Date of Last Dose	Prescriber Orders			
					Continue	Change	**STOP**	Comments / Rationale
ERYTHROMYCIN 250MG TABLET **(Erythromycin Base)** **2016-Mar-26** Physician, Conform2 (MD)		Oral						
ERYC 333 MG CAPSULE EC **(Erythromycin Base)** **2016-Jan-16** Physician, Conform2 (MD)		Oral						
MINOCYCLINE 50 MG CAPSULE **(Minocycline HCL)** **2016-Apr-25** Physician, Conform2 (MD)		Oral						
FAMCICLOVIR 250 MG TABLET **(Famciclovir)** **2016-Mar-07** Physician, Conform2 (MD)		Oral						
VENTOLIN HFA 100 MCG INHALER **(Salbutamol Sulfate)** **2016-Jan-26** Physician, Conform2 (MD)		Oral						
NICORETTE INVISIPA 25 MG/16 HR **(Nicotine)** **2016-Apr-05** Physician, Conform2 (MD)		Oral						

Medication list continues on next page.

SAMPLE

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 _____

Generated from the Pharmaceutical Information Program (PIP), Saskatchewan Ministry of Health on **2016-Apr-27.**

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PREADMISSION MEDICATION LIST / PRESCRIBER ORDER FORM

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Medication Name	Dose	Route	Interval	Time / Date of Last Dose	Prescriber Orders: Continue	Change	STOP	Comments / Rationale
TOLOXIN 0.25 MG TABLET **(Digoxin)** **2016-Apr-23** Physician, Conform2 (MD)		Oral						
ROSUVASTATIN 20 MG TABLET **(Rosuvastatin Calcium)** **2016-Feb-25** Physician, Conform2 (MD)		Oral						
ZESTRIL 10 MG TABLET **(Lisinopril)** **2016-Apr-25** Physician, Conform2 (MD)		Oral						
COZAAR 25 MG TABLET **(Losartan Potassium)** **2016-Feb-25** Physician, Conform2 (MD)		Oral						
TEVA-DICLOFENAC EC 50 MG TAB **(Diclofenac Sodium)** **2016-Jan-27** Physician, Conform2 (MD)		Oral						
Timolol Maleate 0.5 % Ophthalmic Drops **(Timolol Maleate)** Physician, Conform2 (MD)		Oral						

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 _____

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PREADMISSION MEDICATION LIST / PRESCRIBER ORDER FORM

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

Medication Name	Dose	Route	Interval	Time / Date of Last Dose	Prescriber Orders			
					Continue	Change	**STOP**	Comments / Rationale
Prednisone 5 mg Oral Tablet **(Prednisone)** Physician, Conform2 (MD)		Oral						
Comments								
TEVA-METFORMIN 500 MG TABLET **(Metformin HCL)** **2016-Apr-25** Physician, Conform2 (MD)		Oral						
Comments								
Levothyroxine Sodium 100 mcg Oral Tablet **(Levothyroxine Sodium)** Physician, Conform2 (MD)		Oral						
Comments								
ELTROXIN 50 MCG TABLET **(Levothyroxine Sodium)** **2016-Feb-15** Physician, Conform2 (MD)		Oral						
Comments								
Comments								
Comments								

Medication list continues on next page.

SAMPLE

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 _____

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PREADMISSION MEDICATION LIST / PRESCRIBER ORDER FORM

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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, photocopy 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 _____

Generated from the Pharmaceutical Information Program (PIP), Saskatchewan Ministry of Health on **2016-Apr-27.**

SAMPLE