STANDING ORDERS FOR MEDICATION

Client:____ DOB____________________

STANDING ORDERS FOR MEDICATION

PROGRAM: FIRST at Blue Ridge, Inc.

	MEDICATION	TREATMENT GOALS	STRENGTH	ADMINISTRATION DIRECTIONS	Notes
	Daytime Cold and Flu: Acetaminophen 325mg Dextromethorphan Hydrobromide 10mg Phenylephrine 5mg	For relief of cough and cold symptoms.	Acetaminophen 325mg Dextromethorphan Hydrobromide 10mg Phenylephrine 5mg	Swallow one to two soft gels PRN with water every four hours. Do not exceed four doses in 24 hours.	
	Pepto Bismol/ Bismuth Subsalicylate 262mg	For relief of loose bowel movements.	262mg	Take one to two caplets PRN every ½ hour to one hour as needed. Do not exceed more than eight doses in 24 hours.	
	Milk of Magnesia/ Magnesium Hydroxide 1200mg	For relief of Constipation	1200mg	Take one to four tablespoonfuls PRN per day.	
	Tylenol/ Acetaminophen 500mg	For relief of minor aches & pains, and /or fever	500mg	Take one to two caplets PRN every six hours. Do not exceed more than 8 caplets in 24 hours.	
	Ibuprofen 200mg	For relief of minor aches & pains, and /or fever	200mg	Take one to two caplets PRN every four to six hours. Do not exceed more than 12 caplets in 24 hours.	
	Cetirizine Hydrochloride 10mg	For relief of allergy symptoms.	10mg	Take one tablet PRN by mouth once daily.	
	Benadryl/ Diphenhydramine 25mg	For relief of allergy symptoms.	25mg	Take one to two caplets PRN every four to six hours. Do not exceed six doses in 24 hours.	
	Mucus Relief/ Guaifenesin 400mg	Expectorant. To loosen mucus and make coughs more productive.	400mg	Take one caplet PRN every four hours. Do not exceed six doses in 24 hours.	
	Antacid/ Calcium Carbonate 750mg	For relief of heartburn or acid indigestion	750mg	Chew one to two tablets PRN every two to four hours. Do not exceed 5 tablets in 24 hours.	
	Melatonin 3mg	For aid falling asleep.	3mg	Swallow one to two caplets PRN at bedtime.	
	Fish Oil 1000mg	Dietary Supplement	1000mg	Take one caplet with meals up to three times daily.	
	Calamine Lotion Aloe Vera Hydrocortisone Cream 1% Antibiotic Ointment: Bacitracin Zinc/ Neomycin Sulfate/ Polymyxin B Sulfate		Use as directed for minor scrapes, burns, cuts, or itchy skin.		

By my signature below, I acknowledge that during my participation in the First at Blue Ridge, Inc. Residential Treatment Program, I will take only take those Over-The-Counter medications listed above. Further, *I agree only to take recommended doses and for the indicated uses on the Over-The-Counter medication packages. I recognize that it is my responsibility to review the package information, with each dose taken, for any potential adverse interactions and contraindications to my use*. **Further, I hereby agree to hold First at Blue Ridge Inc., and the healthcare provider listed below harmless if I take any over the counter medication not listed above or outside the parameters of recommended dosages, uses and warnings or contraindications.**

Ordered by:____ Date:____

Prescriber Signature

PRINT :____

Client Signature:____ Date:____________________________

Medication Self Administration/Self Possession Authorization

Self-administration means ________________________________ (the client) can administer his/her medication in a manner directed by their physician without additional direction or supervision by FIRST at Blue Ridge Inc staff. Self-possession means that under the direction of the physician, the client may carry medication on his/her person to allow for immediate and self-determined administration. For medication other than inhalers, topical creams, patches and sprays, only that day's supply (24 hours) of medication is to be carried. FIRST at Blue Ridge Inc recommends that spare medication, properly labeled in its original container, to be kept in the FIRST at Blue Ridge Medical Office.

The client agrees to:

1. Never share his/her medication with another person
2. Carry the medication in a responsible manner so as not to lose it
3. Take medication only at the prescribed frequency and dose
4. Keep a copy of this form and back up medication in the FIRST at Blue Ridge Inc Medical Office

If the client fails to meet any of the agreements listed above, FIRST at Blue Ridge Inc may discontinue the Self-Administration/Self-Possession privilege without notice. If FIRST at Blue Ridge Inc revokes the Self-Administration/Self-Possession privilege, client may be discharged from the program.

Physician's Printed Name: ________________________

Physician's Signature: ___________________________ Date _________________

Client's Signature ___________________________ Date _________________

FIRST at Blue Ridge, Inc.

PHYSICIAN ORDERS

Client: ______________________ ______________________ ______________
Last Name First Name Middle Initial

DOB:

ALLERGIES:

PRESCRIBED MEDICATION: List **ALL** medication prescribed by Medical Professionals **INCLUDING ALL OVER THE COUNTER ITEMS.** Sample medication should be dated & marked by Physician.

Clients **MUST** have a 30-day supply and **AT LEAST** a 90-day refill to gain acceptance into our program.

Date	Medication Name	Strength	Administration Directions (Please include route)	Quantity	# of Refills

Even if not on prescription medications, **ALL** forms must be signed.
PLEASE INCLUDE CREDENTIALS.

Qualified Provider (MD, DO, NP, PA) SIGNATURE ______________________________

Qualified Provider (MD, DO, NP, PA) PRINT ______________________________

32 Knox Road
PO Box 40
Ridgecrest, NC 28770
Phone: (828) 669-0011 Ext. 1106/1111
Fax: (828) 669-0596
Website: www.firstinc.org