Sample Prescriptions/Physician’s Medication Orders and Guidelines

Each type of prescriptions or medication physician’s orders, (routine, limited duration, PRN, discontinuation, or hold orders) have different requirements. Please ensure that all elements are contained in the prescription or physician’s orders.

**Routine Medications Must Include:**

Dr. Prescription Heading

Consumer’s Name (Patient): _______________________________________

Name of Drug: _________________________  Strength of Drug: _____________

Dosage given________________ by what route________________ time and frequency of administration _________________________________.

MD Signature ____________________________________  Date:______________

**Limited Duration Medications Must Include:**

Dr. Prescription Heading

Consumer’s Name (Patient): _______________________________________

Name of Drug: _________________________  Strength of Drug: _____________

Dosage given________________ by what route________________ time and frequency of administration __________________________ number of days given ________.  

MD Signature ____________________________________ Date:______________

**PRN Medications Must Include:**

Dr. Prescription Heading

Consumer’s Name (Patient): _______________________________________

Name of Drug: _________________________  Strength of Drug: _____________

Dosage given________________ by what route____________ maximum frequency of administration in a 24-hour period _______________________________________

Condition/Behavior for administering _______________________________________.

MD Signature ____________________________________ Date:______________
Discontinue or D/C Order Medication Must Include:

Consumer’s Name (Patient): ________________________________

Name of Drug: ___________________________ Statement that medication is D/C’d.

Medication time or frequency that is being D/C’s ________________________________.

MD Signature ________________________________ Date: ______________

Hold Order Medication Must Include:

Consumer’s Name (Patient): ________________________________

Name of Drug: ___________________________ Statement that medication is to be held. Number of days to be held ______________ Medication time or frequency that is being held ________________________________ starting on which day ______________.

MD Signature ________________________________ Date: ______________

Important notes: Physician’s orders or prescriptions can be prescribed on a Physician’s Script Pad or Letterhead as well as on a Medication Recap Sheet as long as the prescription or re-cap sheet has the information described previously for each type of medication and is signed by a Physician. All changes or discontinuations made to the order or re-cap sheet must be signed by a Physician. Telephone orders are not acceptable, even when taken by a nurse. All medications must be sent in their original prescription bottles or cards. Medication bottle and card labels and cannot be altered.