CLEAR FORM

TEXAS Department of State Health Services

TX DSHS Public Health Nursing

MEDICATION ORDERS

ALLERGIES:

(For medications that are to be dispensed by clinic pharmacy)

DATE: RX: DOSAGE: ________________
ISSUE: ________________ (AMOUNT)

SIGNATURE:/TITLE____________________________ NOT REFILLABLE: _________
REFILL _____________TIMES

DATE: RX: DOSAGE: ________________
ISSUE: ________________ (AMOUNT)

SIGNATURE:/TITLE____________________________ NOT REFILLABLE: _________
REFILL _____________TIMES

DATE: RX: DOSAGE: ________________
ISSUE: ________________ (AMOUNT)

SIGNATURE:/TITLE____________________________ NOT REFILLABLE: _________
REFILL _____________TIMES

DATE: RX: DOSAGE: ________________
ISSUE: ________________ (AMOUNT)

SIGNATURE:/TITLE____________________________ NOT REFILLABLE: _________
REFILL _____________TIMES

DATE: RX: DOSAGE: ________________
ISSUE: ________________ (AMOUNT)

SIGNATURE:/TITLE____________________________ NOT REFILLABLE: _________
REFILL _____________TIMES

DATE: RX: DOSAGE: ________________
ISSUE: ________________ (AMOUNT)

SIGNATURE:/TITLE____________________________ NOT REFILLABLE: _________
REFILL _____________TIMES

TWICES LABEL HERE

adhere pt. ID sticker here

Cl. Name: ____________________

SS# ____________________

ID# ____________________

DOB: ____________________

TEXAS Department of State Health Services
TX DSHS Public Health Nursing

MEDICATION ORDERS

MEDICATION	1. Date 2. Amount Given 3. Route Site 4. Lot #.Manufacturer 5. Signature/Title	1. Date 2. Amount Given 3. Route Site 4. Lot #.Manufacturer 5. Signature/Title	1. Date 2. Amount Given 3. Route Site 4. Lot #.Manufacturer 5. Signature/Title	1. Date 2. Amount Given 3. Route Site 4. Lot #.Manufacturer 5. Signature/Title
	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.
	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.
	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.
	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.
	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.
	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.
	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.

TWICES LABEL HERE

adhere pt. ID sticker here

Cl. Name: ______________________

SS# ______________________

ID# ______________________

DOB: ______________________