Winnipeg Regional Health Authority
Office régional de la santé de Winnipeg

FAX COVER SHEET for DISCHARGE ORDERS

DATE:		
TO:	Community pharmacy:	
	Fax #	Phone #:
	Discharge Date:	☐ Patient to pick up
	Deliver Medications to: ☐ Home address	☐ other:
☐		Fax #:
☐	General Practitioner	Fax #:
FROM:	WARD:	
	PHONE #:	Fax #:
	SENT BY (name):	

# pages (including cover)	

Attention COMMUNITY PHARMACY:

- We are sending you a Discharge Prescription Form for a patient being discharged from our ward
- **This DISCHARGE PRESCRIPTION FORM is an outpatient prescription once the discharging physician signs and dates it and specifies the quantity to be dispensed.**
- Other care providers may receive a fax of this prescription "for information only"
- Contact the patient prior to dispensing to confirm which medications are needed.
- Active medication orders have the continue box checked in the sections "Scheduled or PRN Medications at time of Discharge" or the "restart" box checked from the section "Pre-admission Medications not ordered in Hospital."
- Discontinue the medication orders that have the "discontinue" box marked if currently on your patient profile
- All orders written in the "New and Changed Medications at time of Discharge" section are active orders.
- The concentration of the medication that appears on the discharge order form is not what is required to be dispensed. It is RECOMMENDED the same concentration is dispensed to reduce the risk of medication error.

NOTICE OF PRIVILEGE AND CONFIDENTIALITY
The documents accompanying this transmission contain confidential information intended for a specific individual and purpose. Any unauthorized distribution, copying, disclosure or dissemination of this transmission or unauthorized taking of any action in reliance on the contents of this transmission is strictly prohibited. Confidential patient information cannot be released, copied or published in whole or part without the consent of the patient. If you receive this transmission in error, please notify us immediately and return the

Winnipeg Regional Health Authority
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Health Sciences Centre
DISCHARGE Medication Reconciliation/Prescription

820 Sherbrook St, Winnipeg, MB R3A 1R9

Health Sciences Centre Winnipeg

Name: **TEST, MEDREC1**	Sex: Male	Room/Bed: GA4-417-2
MRN: 111111	DOB: 05-May-1948	Admitted: 16-Feb-2010
Weight: _____ kg	Age: 62 years	Doctor:
Address:		
Allergies: NKA.		

Continue	Change (see new order)	Discontinue	Scheduled medications at time of discharge (medications, dose, route, and frequency)	Quantity	Refills	Comments
[ ]	[ ]	[ ]	acetic acid topical 0.25% **Dose: 500 mL** Topical Four times a day	Mitte: 30 days or [ ]:________		
[ ]	[ ]	[ ]	acetylsalicylic acid EC **Dose: 81 mg** Oral Daily	Mitte: 30 days or [ ]:________		
[ ]	[ ]	[ ]	amLODIPine **Dose: 2.5 mg** Oral Twice a day	Mitte: 30 days or [ ]:________		
[ ]	[ ]	[ ]	amoxicillin-clavulanate (500 mg-125 mg) **Dose: 1 EA** Oral Three times a day	Mitte:________ **Anti-infective**		
[ ]	[ ]	[ ]	clopidogrel **Dose: 75 mg** Oral Daily	Mitte: 30 days or [ ]:________		
[ ]	[ ]	[ ]	docusate sodium **Dose: 100 mg** Nasogastric Twice a day	Mitte: 30 days or [ ]:________		
[ ]	[ ]	[ ]	enalapril **Dose: 10 mg** Oral Twice a day	Mitte: 30 days or [ ]:________		
[ ]	[ ]	[ ]	furosemide **Dose: 80 mg** Oral each morning	Mitte: 30 days or [ ]:________		
[ ]	[ ]	[ ]	heparin **Dose: 5000 Units** Subcutaneous Twice a day	Mitte: 30 days or [ ]:________		
[ ]	[ ]	[ ]	insulin novolin NPH **Dose: 10 Units** Subcutaneous Daily	Mitte: 30 days or [ ]:________		

Physician Print Name: ______________________

Physician Signature: ______________________

Date/Time: ______________ Licence #: ______________

Scheduled meds to be provided in bubblepacks? YES NO

Primary Care Physician: ______________________

Contact Primary Care Physician for further refills.

Practitioner Certification

- This prescription represents the original of the prescription drug order.
- The pharmacy addressee noted above is the only intended recipient and there are no others.
- The original prescription has been invalidated and securely filed, and it will not be transmitted elsewhere at another time.

Confidential Facsimile

Pharmacy Name: ______________________

Pharmacy Fax #: ______________________

Phone Number: ______________________

☐ Faxed Initials: ____

Date: ______________ Time: ________

Pharmacist ______________ **Date** ________

(Contact prescriber directly for medication clarifications if NOT signed by a hospital pharmacist.)

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DO NOT REMOVE OR THIN FROM THE CHART
Please place Reconciliation Forms in the Orders Section

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Weight: _____ kg Age: 62 years Doctor:
Address:
Allergies: NKA.

Continue	Change (see new order)	Discontinue	Scheduled medications at time of discharge (medications, dose, route, and frequency)	Quantity	Refills	Comments
[ ]	[ ]	[ ]	ipratropium 20 mcg/puff **Dose: 2 puffs** Inhaled Every six hours	Mitte: 30 days or [ ]:________		
[ ]	[ ]	[ ]	lactulose **Dose: 20010 mg** Oral Twice a day	Mitte: 30 days or [ ]:________		
[ ]	[ ]	[ ]	LORazepam **Dose: 3 mg** Oral Three times a day	Mitte: 30 days or [ ]:________		
[ ]	[ ]	[ ]	metoprolol **Dose: 12.5 mg** Oral Twice a day	Mitte: 30 days or [ ]:________		
[ ]	[ ]	[ ]	NIFEdipine XL **Dose: 60 mg** Oral Daily	Mitte: 30 days or [ ]:________		
[ ]	[ ]	[ ]	simvastatin **Dose: 20 mg** Oral Bedtime	Mitte: 30 days or [ ]:________		

Physician Print Name: ____________________

Physician Signature: ____________________

Date/Time: ____________________ Licence #: ____________________

Scheduled meds to be provided in bubblepacks? YES NO

Primary Care Physician: ____________________

Contact Primary Care Physician for further refills.

Confidential Facsimile

Pharmacy Name: ____________________

Pharmacy Fax #: ____________________

Phone Number: ____________________

☐ Faxed Initials: ____

Date: ____________________ Time: ________

Pharmacist ____________________ **Date** ________

(Contact prescriber directly for medication clarifications if NOT signed by a hospital pharmacist.)

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Admitted: 16-Feb-2010
Weight: _____ kg
Age: 62 years
Doctor:
Address:
Allergies: NKA.

Continue	Change (see new order)	Discontinue	PRN medications at time of discharge (medications, dose, route, and frequency)	Quantity	Refills	Comments
[ ]	[ ]	[ ]	acetaminophen **Dose: 325-650 mg** Oral Every 6 hours as needed	Mitte: 30 days or [ ]:________		
[ ]	[ ]	[ ]	HYDROmorphone **Dose: 1 mg** Oral Every 4 to 6 hours as needed.	Mitte:________ **Narcotic**		
[ ]	[ ]	[ ]	metoclopramide **Dose: 10 mg** Oral Every 8 hours as needed	Mitte: 30 days or [ ]:________		
[ ]	[ ]	[ ]	salbutamol 100 mcg/puff (200 dose) **Dose: 2 puffs** Inhaled Every 6 hours as needed	Mitte: 30 days or [ ]:________		

Physician Print Name: ________________________

Physician Signature: ________________________

Date/Time: ________________ Licence #: ____________

Scheduled meds to be provided in bubblepacks? YES NO

Primary Care Physician: ________________________

Contact Primary Care Physician for further refills.

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Pharmacy Name: ________________________

Pharmacy Fax #: ________________________

Phone Number: ________________________

☐ Faxed Initials: ____

Date: ________________ Time: ________

Pharmacist ________________ **Date** ________

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Weight: _____ kg Age: 62 years Doctor:
Address:
Allergies: NKA.

Restart	Discontinue	Pre-admission medications not ordered in hospital (medications, dose, route, and frequency)	Quantity	Refills	Comments

New and changed medications at time of discharge (medications, dose, route, and frequency)	Quantity	Refills	Comments

Physician Print Name: ____________________

Physician Signature: ____________________

Date/Time: ____________ Licence #: ____________

Scheduled meds to be provided in bubblepacks? YES NO

Primary Care Physician: ____________________

Contact Primary Care Physician for further refills.

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Pharmacy Fax #: ____________________

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Pharmacist ____________ **Date** ________

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