Health Sciences Centre
Winnipeg

DATE

PATIENT

DOB

HSC NO.

PHYSICIAN ORDER SHEET
HOME MEDICATIONS *ONLY* CHILD HEALTH ADMISSIONS (Side 1)

Weight (kg): _____ **Height (cm):** _____ **BSA:** _____

Allergies: ☐ **Yes** ☐ **No Known Allergies**

Medications/Food/Environment/Latex	What is the Reaction?	How Long Ago?	Subsequent Trial and Tolerance?

☐ On No Medications at Home
☐ Unable to Obtain Medication History Reason: _____

HOME MEDICATIONS *ONLY* (PLEASE PRINT)	DOSE	ROUTE	FREQUENCY	FORM (i.e. liquid, tab) & CONCENTRATION (mg/ml)	DOSAGE **(mg/kg/day or mg/kg/dose)**	LAST TAKEN (Date/Time)	**PHYSICIAN ADMISSION ORDERS (Check One)** CONTINUE	CHANGE*	DO NOT ORDER	REASON FOR CHANGE/ DO NOT ORDER
							☐	☐	☐	
							☐	☐	☐	
							☐	☐	☐	
							☐	☐	☐	
							☐	☐	☐	
							☐	☐	☐	
							☐	☐	☐	
							☐	☐	☐	
							☐	☐	☐	

Ordering Physician Signature: **Date:** **Time:**

Medication History Taken by: _____ **Date:** _____ **Time:** _____

Nurse's Signature: _____ **Date:** _____ **Time:** _____

Orders Transcribed/Verified by: _____ **Date:** _____ **Time:** _____

***CHANGE:**
Write new order on Inpatient Physician Order Sheet

FORM # NS00850 01/07

Do not add additional meds to this sheet once faxed

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PHYSICIAN ORDER SHEET
HOME MEDICATIONS *ONLY*
CHILD HEALTH ADMISSIONS (Side 2)

DO YOU TAKE ANY OF THE FOLLOWING?

Inhalers	☐ Yes	☐ No	Nasal Mists	☐ Yes	☐ No
OTCs	☐ Yes	☐ No	Patches	☐ Yes	☐ No
Herbals	☐ Yes	☐ No	Eye/Ear Drops	☐ Yes	☐ No
Tube Feeds	☐ Yes	☐ No	Injectables	☐ Yes	☐ No
Creams/Ointments	☐ Yes	☐ No			

Information Source (check all that apply):

☐ Patient ☐ Parent/Guardian ☐ Medication List
☐ DPIN ☐ Transfer Sheet ☐ Community Pharmacy
☐ Physician (specify physician/specialists) _____
☐ Other (specify) _____

Medications given by a nurse/physician in a clinic? _____
_____

Any other medications that are not taken by the child due to adverse effects? _____
_____

Any street drug use? _____

Patient's Usual Pharmacy:
Name _____ Phone _____

Patient's Alternate Pharmacy:
Name _____ Phone _____

Compliance and Assessing Education requirements:

How many doses of medication did this child miss in the last week? _____

How often does this happen? ☐ once a month ☐ once a week ☐ less

Why is it forgotten i.e.: side effects/timing/cost? _____

Has the dose been changed in the last 1-2 weeks? ☐ Yes ☐ No

Has this child stopped taking any medications in the past month? _____

Who is responsible for administering this child's medication? _____

Does the parent/child bring all medications (prescription, nonprescription and herbals) to the hospital/doctor's office? _____

For each medication, can the parent/child state the reason for taking it? _____

Comments: _____
_____

Faxed to Children's Pharmacy (fax #): 787- _____ **Date:** _____ **Time:** _____