MEDICATIONS AND THERAPEUTIC MODALITIES	ALLERGIES-DRUG REACTIONS:
PATIENT	PHONE NO:
PHARMACY / THERAPIST	PHONE NO:

Problem Number or Letter		MEDICATION / SIGNATURE / AMOUNT DISPENSED	NURSE TO REFILL	DATE		REFILLS / DATE / STRENGTH / INITIALS			
				Start	Stop				
			YES NO						
			YES NO						
			YES NO						
			YES NO						
			YES NO						
			YES NO						
			YES NO						
			YES NO						
			YES NO						
			YES NO						
			YES NO						
			YES NO						
			YES NO						
			YES NO						
			YES NO						
			YES NO						
			YES NO						

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