Southern Health Santé Sud

Discharge Medication Plan and Prescription

Legend

Continued Home Medication: Client came in on these medications and no changes occurred upon discharge
Adjusted Home Medication: Client came in on these medications but a change occurred (ie.)Dosage/Route/Frequency
New Medication: Client was not receiving this medication prior to admission
Discontinued Medication: Client was receiving this medication prior to admission but is no longer required
White – Patient or Pharmacy **Yellow** – Primary Care Provider **Pink** – Patient Chart
Forward a photocopy to Homecare, Palliative Care, PCH &/or other services as applicable

Hospital: _____ **Unit:** _____

Primary Care Provider: _____

Primary Care Provider Clinic: _____

Allergies: _____

Medication, Dose, Route Frequency	Schedule (optional)				Continued Home Medication	Adjust Home Medication	New Medication	Any change to original home medications & newly prescribed medications requires a comment	Quantity & Refill
	Morning	Noon	Supper	Bed					
					☐	☐	☐		Q: R:
					☐	☐	☐		Q: R:
					☐	☐	☐		Q: R:
					☐	☐	☐		Q: R:
					☐	☐	☐		Q: R:
					☐	☐	☐		Q: R:
					☐	☐	☐		Q: R:
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					☐	☐	☐		Q: R:
					☐	☐	☐		Q: R:
					☐	☐	☐		Q: R:

Discontinued/Stopped Home Medications (Please provide rationale/comment)

Comment:

Comment:

Comment:

Prescriber Information

Name: _____

Signature: _____

Date/Time: _____ **License #:** _____

Address: _____

Fax #: _____

Phone #: _____

Confidential Facsimile To:

Pharmacy Name: _____

Pharmacy Fax #: _____

☐ Faxed Initials: _____ Date/Time: _____

Or

☐ Original Given to Client

Med Rec Verified by (Nurse's Signature): _____

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 will be invalidated and securely filed, and not transmitted elsewhere at another time.