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Medication Record

Metro Support Services, Inc.

MEDICATION	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Nursing Order: Track BMs if no BM by 3rd day refer to bowel protocol																																
Start Date:																																
Start Date:																																
Start Date:																																
Start Date:																																
Start Date:																																
Start Date:																																

NAME	ALLERGIES	DIET	INITIALS	SIGNATURE
DIAGNOSIS				
	HOST HOME	PHYSICIAN NAME & PHONE		MONTH & YEAR:

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PRN MEDICATION RECORD

Refer to approved over the counter prn list or specific physician's order for prn medications.
For interventions: Circle initials on medication record and chart interventions below.
Use key for type of intervention (reason).

Administration Routes	**(O)** – Oral **(R)** – Rectal **(T)** – Topical	**(S)** – Sublingual **(I)** – Inhaled **(V)** - Vaginal	**Interventions**	**(OOH)** – Out of Home **(E)** – Medication Error	**(H)** – In Hospital **(R)** – Refused Medication

Date	Hour	Medication & Dosage	Route	Reason	Results or Response	Hour	Provider's Signature