

Lane County Developmental Disabilities
Adult Foster Home

Medication Orders

Patient's Name: _____

| <u>Medication/Dose</u> | <u>Hours of Administration</u> | <u>Method</u> |
|------------------------|--------------------------------|---------------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |
| 5. _____ | _____ | _____ |
| 6. _____ | _____ | _____ |
| 7. _____ | _____ | _____ |

The following over the counter medications may be given to my patient as needed:

Please list any side effects that we must watch for in this particular patient:

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____

(Oregon Administrative Rule requires that residents of Adult Foster Homes have written orders for medications on file in the Foster Provider's chart for the resident.)