

# Mary S. Shook Student Health Service

APPALACHIAN STATE UNIVERSITY

614 Howard Street ~ ASU Box 32070 ~ Boone, North Carolina 28608 ~ (828) 262-3100 ~ fax (828)262-6958

## MD ORDER FOR MEDICATION TO BE ADMINISTERED BY AppState HEALTH SERVICE STAFF

Student/Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Patient's Diagnosis: \_\_\_\_\_ Diagnosis Code: \_\_\_\_\_

Prognosis and brief plan of care: \_\_\_\_\_

## MEDICATION TO BE ADMINISTERED BY AppState HEALTH SERVICE STAFF

Medication Name: \_\_\_\_\_

Dose: \_\_\_\_\_ (units) Concentration: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency: \_\_\_\_\_

Flexibility in dose frequency: \_\_\_\_\_

Observation time in clinic after injection: \_\_\_\_\_

Number of doses to be given at AppState: \_\_\_\_\_

**\*Date of last dose of medication\***(if applicable): \_\_\_\_\_

Do we have your permission to teach the student how to administer this medication, if applicable? \_\_\_\_\_

Other Instructions: \_\_\_\_\_

## LABWORK to be drawn at AppState Health Service (if applicable)

Labs Ordered: \_\_\_\_\_

Date Labs (date or range of time that labs should be drawn): \_\_\_\_\_

Will medication dose or frequency change as a result of lab results? \_\_\_\_\_

Should medication be withheld until labs are reviewed by clinician? \_\_\_\_\_

## SIGNATURE

Ordering physician (print): \_\_\_\_\_ Ordering Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Best contact person for communication in your office: \_\_\_\_\_

Phone number of contact person: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Clinic Address: \_\_\_\_\_

Approved by AppState SHS Medical Director: \_\_\_\_\_