Monroe Surgical Hospital

PATIENT NAME:_____

Allergy to: Iodine_____, Latex_____, Other _____

DATE OF BIRTH:_____

ADMISSIONS MEDICATIONS LIST:

TWO PATIENT IDENTIFIERS CONFIRMED_____

MEDICATION NAME	**DOSAGE**	**DATE/TIME LAST DOSE**

Comments:_____

_____

Pharmacy Signature:_____Date/Time_____

Patient Signature:_____Date/Time_____

KEEP THIS FORM WITH PHYSICIAN ORDERS