

PHYSICIAN FAX / COMMUNICATION ORDER

Long-term Care

Facility / Unit: _____ Weight (kg) _____

 Tel: _____ Fax: _____ **MRP:** _____

Pharmacy Name: _____ Phone: _____ Fax: _____

- Emergent:** Need to speak with a Physician now or within the hour (call required to physician and fax this form).
 Urgent: Need to ensure physician will respond within 4 hours. Situation requires early intervention for follow up.
 Routine: Need to ensure physician will see this within 24 hours. Situation is stable but requires advice.

To:	Resident:	Date:	Time:
SDM (name):		Phone:	
Situation	Problem / Concern:		
	<input type="checkbox"/> Change in Mental Status <input type="checkbox"/> Blood Pressure/Pulse <input type="checkbox"/> Respiratory <input type="checkbox"/> Pain <input type="checkbox"/> Diabetic <input type="checkbox"/> GI/Urinary <input type="checkbox"/> Musculoskeletal/Fall <input type="checkbox"/> Integument <input type="checkbox"/> Diabetic <input type="checkbox"/> Behavioural Concern <input type="checkbox"/> Other: _____		
Background	Related Medication Information _____		
	Relevant Medical History _____ Allergies: <input type="checkbox"/> NKA <input type="checkbox"/> See Allergy ADR Record <input type="checkbox"/> MOST Designation _____ <input type="checkbox"/> MAR (send if discussing med changes) <input type="checkbox"/> Other: _____		
Assess	Blood glucose _____ mmol/L Temp _____ BP _____ / _____ Pulse _____ Resp _____ SpO ₂ _____ O ₂ <input type="checkbox"/> Yes <input type="checkbox"/> No _____ L/min LOC: <input type="checkbox"/> Alert <input type="checkbox"/> Drowsy <input type="checkbox"/> Fluctuates Other: _____		
	<input type="checkbox"/> Call to Discuss <input type="checkbox"/> Visit and Assess <input type="checkbox"/> Orders Comments: _____		
Request	Name / Designation:		Signature:

Prohibited Abbreviations	Correct Term	Prohibited Abbreviations	Correct Term	Prohibited Abbreviations	Correct Term
U, IU, u or iu	Unit	D/C	discharge or discontinue	> or <	greater than or less than
QD or qd	DAILY	cc	mL	trailing zero (X.0 mg)	never use zeros AFTER decimal
QOD or qod	every other day	ug	mcg	lack of leading zero (.X mg)	always use zeros BEFORE decimal
drug name abbreviations	write generic drug names	@	at	OS, OD, OU	left eye, right eye, both eyes

Physician Orders	If narcotic or controlled substance, specify quantity. UNLESS OTHERWISE INDICATED all medication orders, excluding narcotics and controlled substances will be: <ul style="list-style-type: none"> • for 200 days • initiated / discontinued with next weekly medication delivery 	Processing (initial)
		<input type="checkbox"/> Faxed to Pharmacy <input type="checkbox"/> Discontinued on MAR <input type="checkbox"/> Med Roll Removed <input type="checkbox"/> Started from Contingency <input type="checkbox"/> Med Received <input type="checkbox"/> MAR Updated <input type="checkbox"/> Req. Entered <input type="checkbox"/> Appt. Made

Date (dd/mm/yyyy)	Time	Physician Signature	College ID#
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