Interior Health

PHYSICIAN FAX / COMMUNICATION ORDER

Long-term Care

Facility / Unit: _____ Weight (kg)

Phone: _____ 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:

☐ Change in Mental Status ☐ Blood Pressure / Pulse ☐ Respiratory ☐ Pain ☐ Diabetic ☐ GI / Urinary
☐ Musculoskeletal / Fall ☐ Integument ☐ Diabetic ☐ Behavioural Concern ☐ Other: _____

Background

Related Medication Information _____

Relevant Medical History _____

Allergies: ☐ NKA ☐ See Allergy ADR Record ☐ MOST Designation ____ ☐ MAR *(send if discussing med changes)*
☐ Other:

Assess

Blood glucose _____ *mmol / L* Temp _____ BP _____ / _____ Pulse _____ Resp ____ SpO_2 ____

O_2 ☐ Yes ☐ No ____ *L / min* LOC: ☐ Alert ☐ Drowsy ☐ Fluctuates Other:

Request

☐ Call to Discuss ☐ Visit and Assess ☐ Orders
Comments:

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:
- **for 200 days**
- **initiated / discontinued with next weekly medication delivery**

Processing *(initial)*

____ Faxed to Pharmacy
____ Discontinued on MAR
____ Med Roll Removed
____ Started from Contingency
____ Med Received
____ MAR Updated
____ Req. Entered
____ Appt. Made

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

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