Champlain Community Services
512 Troy Avenue, Suite 1
Colchester, VT 05446
(802) 655-0511 (Phone) Fax 655-5207

TELEPHONED Physicianôs Medication/Treatment **ORDERS**

Date/year: _____ Time: _____ Your Name: _____

Clientôs Name: _____ Doctorôs Name: _____

The following telephoned instructions are a change in:

MEDICATION___DOSE___SCHEDULE___TREATMENT___OTHER___.

YOU <u>CAN</u> ASK THE DR'S OFFICE TO FAX THIS ORDER DIRECTLY TO CCS IF POSSIBLE

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<u>GUIDELINES</u>

1) **ORDER MUST INCLUDE:**
   a) **NAME OF MEDICATION / TREATMENT**
   b) **DOSE AND FREQUENCY**
   c) **MAXIMUM DURATION OF TREATMENT FOLLOWED BY WHAT TO DO IF PROBLEM PERSISTS.**
2) **TRANSCRIBE THIS ORDER TO MED/TREATMENT SHEET**
3) **SEND ORIGINAL *IMMEDIATELY* TO CCS OFFICE** (photocopy first, if possible)
4) **OFFICE WILL ROUTE ORDER TO BE SIGNED BY DOCTOR WITHIN 14 DAYS, YOU MUST VERIFY WHO IS GIVING THIS INSTUCTION-ONLY A PHYSICIAN, R.N., (OR P.A.) CAN ISSUE A TELEPHONED MED ORDER** (not a secretary, LPN, etc)

Physicianôs Signature: _____ Date: _____

Your Signature: _____ Date: _____