EMORY HEALTHCARE

EMORY HOSPITALS

Admission Orders for Medications PRIOR to Admission

Allergies: Drug/Foods	Reactions/Side Effects
❑ NKDA	

Patient has a **latex** allergy or sensitivity? ❑ Yes ❑ No ❑ Unsure

If yes, describe type of reaction: _____

Patient allergic to **iodine**? ❑ Yes ❑ No

Patient allergic to **X-ray contrast**? ❑ Yes ❑ No

Patient pregnant or lactating? ❑ Yes ❑ No

Height: Actual _____ ft/in or Estimated _____ ft/in

Weight: Actual _____ **kg** or Estimated _____ **kg**

Original page ___ of ___ ❑ **Amendment** to Original

Pneumovax within last 5 years: ❑ **Yes** ❑ **No** ❑ **NA** ❑ **Unknown**

Influenza vaccine this season: ❑ **Yes** ❑ **No** ❑ **NA** ❑ **Unknown**

Immunization status of 2 mos.-12 years:

❑ Up to date ❑ Referred to family physician to update immunizations

❑ **Unable to Obtain Medication History -**

Reason: _____

Information Source(s): ❑ Patient ❑ Caregiver

❑ Medication List _____ ❑ Facility MAR/Med List

❑ Acute Care Hospital MAR/Med List

❑ Other (Specify) _____

❑ Medications here from home: ❑ *Sent to Inpatient Pharmacy*

❑ *Sent home with Family/Friend* _____

❑ *Patient declined to surrender medications*

This form is NOT for new medications. Medications initiated at admission need to be on separate order form.

Medications PRIOR to Admission (Med PTA) (Include Pills, Patches, Inhalers, Eye Drops, Over the Counter Medications and Supplements*) *Per hospital policy alternative medications can NOT be taken by inpatients; please check DO NOT ORDER						Medication Orders on Admission (Check one box per drug)		
Drug Name (generic name preferred) ❑ No Medication PTA	Strength	# of Tabs / Caps/mLs/units & Frequency	Route	Indication/ Purpose	Last Taken: Date/Time or UK (unknown)	Order Unchanged	Change (Use Order Sheet)	Do NOT Order
1						❑	❑	❑
2						❑	❑	❑
3						❑	❑	❑
4						❑	❑	❑
5						❑	❑	❑
6						❑	❑	❑
7						❑	❑	❑
8						❑	❑	❑
9						❑	❑	❑
10						❑	❑	❑

Comment: _____

Person(s) Gathering Medication History: _____ Date/Time _____

_____ Date/Time _____

Before signing this form confirm medications prior to admission with the appropriate information source.

Prescriber Signature: _____ Date/Time _____ Contact # _____

This form should be the BOTTOM sheet in the Physician Order Section – Do Not Remove from Chart