PULMONARY AND CRITICAL CARE SPECIALISTS
of NORTHERN VIRGINIA, P.C.

MEDICATION LIST

PATIENT: _____ **DATE:**____/____/_____
(Last Name) (First Name)

Medication ALLERGIES: _____

Nebulizer: _____ **Oxygen:** _____ **CPAP/BiPAP:** _____/**Setting:** _____

Home Health Equipment/Supply Company:_____

Preferred Pharmacy Name/Phone #: _____

Please list ALL medications, prescription and over-the-counter, regardless of the prescribing physician.

MEDICATION	DOSAGE	FREQUENCY	ORDERING PHYSICIAN
_____	_____	every _____ hours	_____
_____	_____	every _____ hours	_____
_____	_____	every _____ hours	_____
_____	_____	every _____ hours	_____
_____	_____	every _____ hours	_____
_____	_____	every _____ hours	_____
_____	_____	every _____ hours	_____

OVER-THE-COUNTER MEDICATIONS: _____

_____

PRESCRIPTIONS NEEDED TODAY

MEDICATION	LOCAL PHARMACY or MAIL-IN *(please circle preference)*
_____	_____
_____	_____
_____	_____

PATIENT SIGNATURE_____ **DATE**_____

NOTE: Please print and bring to your appointment.