Sample Form for Taking Verbal Orders:

Name of individual for whom the medication or Health-related Activity (H-R) is for: _____

Name of person receiving the verbal order _____

Name of second person listening to verify order if applicable _____

Name of 2nd person checking the order (next shift, etc.) _____

Date: _____ Date medication or H-R activity is to begin: _____

Name of medication or H-R activity: _____

Dosage (size or amount, eg. Milligrams, micrograms, milliliters, # of): _____

Exact time or times the medication is to be given or H-R activity that is to be done: _____

Route of Medication:	☐ Oral ☐ Topical ☐ Rectal ☐ Vaginal	**NOSE** ☐ Right Nares ☐ Left Nares ☐ Both Nares	**EYE** ☐ Right Eye only ☐ Left Eye only ☐ Both Eyes	**Other:**

Length of time medication is to be given or Health-Related activity is to be done: _____

Reason for medication or H-R activity: _____

Special instructions for medication administration or reporting observations during health-related activity:

Allergies: _____

Side effects or contra-indications: _____

_____

Repeat the order back to the health care professional? ☐ Yes ☐ No

Hard copy of order obtained? ☐ Yes ☐ No

Signature and date of personnel receiving hard copy of this order: _____