TurningPoint

STANDING ORDER MEDICATIONS AUTHORIZATION

CLIENT NAME _____ Date _____ TP Site _____

Medication Allergies: _____

To physician: Please indicate whether or not each of these medications can be administered to the above client by initialing in the appropriate box. This Authorization is in effect for one year from the date signed.
To staff: Follow the instructions. Refer the client to the physician if the client requests for standing order medications for 4 or more separate episodes a month.

Physician Initials

Indication	Medication & Dosage	Instructions	Yes	No
PAIN Headache, Mild Muscle or Joint Pain	**Ibuprofen (Advil)** 200mg - 1-2 tablets every 4-6 hrs with food	1. Give for 48 hrs as needed only for any complaint 2. If persistent, contact physician		
	Acetaminophen (Tylenol) extra strength 500mg every 4-6 hrs. Max 4000mg/24 hrs			
	ASA (Aspirin) 325mg every 4-6 hrs			
FEVER Temp. above 37.5 C	**Acetaminophen extra strength** 500mg every 4-6 hrs. Max 4000mg/24 hrs	1. If fever increases, contact physician 2. If fever persists beyond 24 hrs, contact physician		
COUGH	**Buckley's** (or similar cough syrup) 5–10 ml (1-2 tsp) every 4-6 hrs **Cough Lozenges** 1 lozenge every 3 hrs	1. Give for 48 hrs as needed 2. If persistent, contact physician		
STUFFY NOSE / SINUS CONGESTION	**Sinus Medication Daytime (non-drowsy)** (or similar) Acetaminophen/Pseudoephedrine (500/30mg) 1 tablet every 12 hrs. Max 4000mg/24 hrs from all acetaminophen sources, **OR** **Sinus Medication Nighttime (drowsy)** (or similar) Acetaminophen/Pseudoephedrine/Doxylamine (500/30/6.25mg) or Acetaminophen/Pseudoephedrine/ Chlorpheniramine (500/30/2mg) 1 tablet every 12 hrs. Max 4000mg/24 hrs from all acetaminophen sources	1. Give for 48 hrs as needed 2. If persistent, contact physician		
SORE THROAT	**Cepacol / Fisherman's Friend Lozenges** 1 lozenge every 3 hrs	1. Give for 48 hrs as needed 2. If persistent, contact physician		
NAUSEA / VOMITING Lasting more than 6 hrs	**Dimenhydrinate (Gravol)** 50 mg every 6 hrs	1. Give for 48 hrs as needed 2. If persistent, contact physician		
INDIGESTION Complaints of burning epi-gastric pain	**Calcium Carbonate (Tums)** 1 or 2 as needed. Max 8/day, **OR** **Aluminum Hydroxide/Magnesium Hydroxide (Diovol)** 10-20ml (2-4 tsp) up to 4xday. Max 16 tsp/day, **OR** **Bismuth Subsalicylate (Pepto Bismol)** 15-30ml (1-2 tbsp) 4xday	1. Give for 24 hrs as needed 2. If persistent, contact physician		
DIARRHEA More than one watery bowel movement	**Attapulgite 600mg/15ml (Kaopectate)** 30ml (2tbsp) after each loose bowel movement. Max 7 doses/24 hours, **OR** **Loperamide (Imodium)** 2 mg - 2 caplets, then 1 caplet after each loose bowel movement. Max 8/day	1. Give for 24 hrs as needed only 2. Contact physician if condition worsens or persists		
CONSTIPATION	**Prune Juice** 1 cup every 6 hrs for 24 hrs **Sennosides** 8.6 mg - 1-3 tablets 1xday for 48 hrs	1. Contact physician if condition worsens or persists		
CUTS, BITES	**Polysporin ointment (or equivalent)** Apply to the affected area(s) as needed **Hydrogen Peroxide** 10 vol 3% " **Rubbing Alcohol** 70% v/v "	1. Contact physician if worsens		
ALLERGIC REACTIONS Itching, Sneezing, Runny/Nose/Congestion, Rash, Hives	**Loratadine (Claritin) 24 hr** 10 mg 1 tablet daily as needed **Calamine Lotion** – apply as needed	1. Contact physician if no improvement after 4 days		

Physician Name _____ **CPSID #** _____ **Tel #** _____

Physician Signature _____ **Date** _____

TurningPoint

VITAMINS & SUPPLEMENTS AUTHORIZATION

CLIENT NAME _____ Date _____ TP Site _____

NOTE: Only vitamins and supplements deemed medically necessary by a Physician will be administered

Supplement & Strength	Instructions	Continue	D/C	Qty Authorized
e.g. Vitamin D 1000 IU	*Take one tablet by mouth daily in the morning*	√		*3 months (90 tablets)*

Physician Name _____ CPSID # _____

Physician Signature _____ Date _____

Physician Telephone # _____

Fax completed form to Turning Point Fax Number: _____

Turning Point Staff: *Fax completed form to Pharmacy & file with Client's MAR*

BRITISH COLUMBIA
Ministry of Health

Ministry of Health

PHARMACY
ACCESS TO PHARMANET AGREEMENT

PHARMANET
Patient Consent to Access PharmaNet

The Province of British Columbia has established the provincial pharmacy network and database known as "PharmaNet" pursuant to section 37 of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act,* R.S.B.C. 1996, c. 363, and which may be continued pursuant to section 13 of the *Pharmacy Operations and Drugs Schedule Act,* S.B.C., 2003, c. 77 should it be proclaimed in force during the term of this Agreement.

I, _____, authorize Script Care Pharmacy
Name of Patient (print) *Name of Pharmacy (print)*

to access my personal health information contained within PharmaNet for the purpose of providing therapeutic treatment or care to me, or for the purpose of monitoring drug use by me.

I understand that withdrawal of this consent must be in writing and delivered to the above-named pharmacy.

Executed at _____, this _____ day of _____, 20____.

SIGNED AND DELIVERED by)

_____)
Patient (print))

in the presence of:)

_____)
Witness (signature))

_____)
Witness (print))

_____)
(Dated))

_____
Patient (signature)