

## PATIENT INSTRUCTIONS FOR SAMPLE MEDICATIONS GIVEN

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Dispensing Provider: \_\_\_\_\_

Medication Given: \_\_\_\_\_

Quantity Given: \_\_\_\_\_ Dose: \_\_\_\_\_ Lot# \_\_\_\_\_

Patient Allergies: \_\_\_\_\_

Patient Instructions: (Dose, Route, Frequency, Special Instructions)

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Possible Side Effects or Adverse Reactions:

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If you have any questions or concerns while taking this medication, please call our office at \_\_\_\_\_.

The above information has been reviewed with me. I was given an opportunity to ask questions, and they have been answered to my satisfaction. I have been given a copy of these instructions.

Patient \_\_\_\_\_ Staff \_\_\_\_\_

Copy to patient  
Copy to chart



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If you would like to discuss a particular situation, please contact our risk management division at 1-888-336-2642 or [riskmanagement@psicinsurance.com](mailto:riskmanagement@psicinsurance.com).