7day MAR / FADM 7jours

Name:_____

D.O.B:_____

Room:_____

Chart:_____

Valid from : _____/_____/ _____ until _____/ _____/_____

Day(xx) Month (xx) Year(xxxx) Day (xx) Month (xx) Year (xxxx)

Allergie(s):_____ Intolerance(s):_____

Medication(s)		DATES						
Ibuprofen 400mg PRN PO q8hr Available in 200 mg /co	-prn-							
	-prn-							
	-prn							
	-prn-							
Oxycodone 5mg PRN PO q6hr Available in 2.5 mg/co	-prn-							
	DV							
	-prn-							
	DV							
	-prn-							
	DV							
Acetaminophen 325mg PRN PO q4hrs Available in 325mg/co	-prn-							
	-prn-							
	-prn-							
	-prn-							
	-prn-							

Initial	Signature	Initial	Signature	Initial	Signature
Initial	Signature	Initial	Signature	Initial	Signature
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7day MAR / FADM 7jours

Name:_____

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