PEARDONVILLE HOUSE
TREATMENT CENTRE

THIS FORM MUST BE FILLED OUT AND SIGNED BY A PHYSICIAN

Please indicate whether the client is able to have the following prescriptions by placing your initials next to the meds she may have while in treatment.

Standing Order Medication Form **Client Name:** _____

Indication	Medication and Guidelines	YES	NO
Pain & fever or inflammation	Acetaminophen 500 mg 1-2 tabs up to four times a day and/or Ibuprofen 200mg 1-2 tabs up to three times per day If client is taking anti-inflammatories DO NOT GIVE IBUPROFEN. Maximum of 72 hours. Contact doctor if more than 72 hours.		
Cough and/or Congestion	Ice Water		
Hayfever	Loratadine 10mg: 1 tab every 24hrs Maximum of 72 hours. Contact doctor if more than 72 hours for new orders		
Hives or itchy rash	Diphenhydramine 25mg: 1-2 tabs every 6 hrs as needed. Maximum 8 tablets/24hrs Maximum of 72 hours. Contact doctor if more than 72 hours.		
Toothache	Insert cotton ball soaked in clove oil into tooth cavity		
Diarrhea	Loperamide 2mg:2 tabs for first dose, then 1 tab after each bowel movement, max 8 tabs/24hrs Maximum of 72 hours. Contact doctor if more than 72 hours.		
Nausea and/or vomiting	Dimenhydrinate 50mg rectal suppository: 1-2 suppositories 3 to 4 times daily. Maximum 400mg/24hrs Maximum of 72 hours. Contact doctor if more than 72 hours.		
Heartburn/indigestion	Magnesium/Aluminum suspension antacid (Gaviscon): 15 to 30mls up to 4x/24 hours. Maximum of 72 hours. Contact doctor if more than 72 hours.		
Severe allergic reaction with swelling of lips, face, neck and throat, wheezing and difficulty breathing	Epi-Pen (Pre-filled epinephrine syringe) injected into thigh 1x AND call 911 immediately		
Bowel Protocol	Encourage all clients to increase dietary fibre, increase fluid intake and increase exercise.		
Constipation Day 1	Increase fibre (prunes, bran), fluid and exercise.		
Constipation Day 2	PEG 3350 (Restoralax): Mix 17gm in 240mls of water and drink		
Constipation Day 3	Sennosides 12mg: 1 to 2 tablets at bedtime		
Constipation Day 4	Glycerin suppository: 1 per day: Unwrap and insert one into the rectum.		
Constipation Day 5	Please notify physician		

Physician's signature: _____ CPSID#: _____

Client signature: _____ Date: _____

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Patient Name: _____

I, Dr. _____ have thoroughly checked the above patient and have found no evidence of Head Lice or Scabies.

Date: _____

Signature: _____

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PRESCRIPTION

- **Peardonville House is not licensed to administer medication brought into treatment by the client**
- Please write out all orders (excluding Methadone/Suboxone) **for a 3-month supply for your patient including OTC medications and vitamins**. WE DO NOT ACCEPT BENZODIAZAPINES, NARCOTICS, OPIATES OR STIMULANTS**.** Peardonville will fill the prescription for the client on arrival.
- Please fax to 604-856-3120 and forward all original triplicate prescriptions to:
  Peardonville House Treatment Center, 825 Peardonville Road, Abbotsford, BC V4X 2L8

Extended Health Benefits Information

Carrier: _____ Carrier #:_____

Plan #: _____ Member ID#: _____

Name of Plan Holder: _____

PLEASE PRINT CLEARLY – if not prescribing any medications, please indicate N/A - this page is required by our pharmacy for every client

Please handwrite "weekly dispense" on the prescription below:

Rx

Client Name: _____

Date: _____

Doctor's Name: _____

Doctor's Signature: _____

PEARDONVILLE HOUSE
TREATMENT CENTRE

BRITISH COLUMBIA
Ministry of Health

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 Rona Loewen (Nurse Practitioner)
Name of Patient (print)

and persons directly supervised by her 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 physician.

Executed at _____, this _____ day of _____, 20___

SIGNED AND DELIVERED by)

_____)
Patient (print))

in the presence of:)

_____) _____
Witness (signature)) ***Patient (signature)***

_____)
Witness (print))

_____)
(Dated))