

Please email orders to:

savanna.jones@doc.ok.gov



Facility: _____ Code: _____

Address: _____

Medical Phone: _____

Fax: _____

WILL ONLY ACCEPT PRINTED HANDWRITING

Inmate New Order Form

Payor	Last Name, First Name	D.O.B.	Allergies	Drug	Strength	Qty Per Dose	Directions/Sig (Choose One)	Length of Order
<input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Other: _____	LN: _____ FN: _____		<input type="checkbox"/> NKDA <input type="checkbox"/> _____ _____ _____			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> ____	<input type="checkbox"/> QD/QAM <input type="checkbox"/> BID <input type="checkbox"/> QPM <input type="checkbox"/> TID <input type="checkbox"/> QHS <input type="checkbox"/> QID <input type="checkbox"/> _____	<input type="checkbox"/> 7 Days <input type="checkbox"/> 10 Days <input type="checkbox"/> 30 Days <input type="checkbox"/> 365 (LOS) <input type="checkbox"/> _____
<input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Other: _____	LN: _____ FN: _____		<input type="checkbox"/> NKDA <input type="checkbox"/> _____ _____ _____			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> ____	<input type="checkbox"/> QD/QAM <input type="checkbox"/> BID <input type="checkbox"/> QPM <input type="checkbox"/> TID <input type="checkbox"/> QHS <input type="checkbox"/> QID <input type="checkbox"/> _____	<input type="checkbox"/> 7 Days <input type="checkbox"/> 10 Days <input type="checkbox"/> 30 Days <input type="checkbox"/> 365 (LOS) <input type="checkbox"/> _____
<input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Other: _____	LN: _____ FN: _____		<input type="checkbox"/> NKDA <input type="checkbox"/> _____ _____ _____			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> ____	<input type="checkbox"/> QD/QAM <input type="checkbox"/> BID <input type="checkbox"/> QPM <input type="checkbox"/> TID <input type="checkbox"/> QHS <input type="checkbox"/> QID <input type="checkbox"/> _____	<input type="checkbox"/> 7 Days <input type="checkbox"/> 10 Days <input type="checkbox"/> 30 Days <input type="checkbox"/> 365 (LOS) <input type="checkbox"/> _____

Date: _____

Verbal Order Per: _____

-OR-

Physician Signature: _____

RN/LPN Signature: _____

Physician DEA #: _____

Physician DEA Required For ALL Control Medication Orders

Physician NPI #: _____

NOTE: If the physician is unavailable to sign this medication order, please check the box marked "Verbal Order" and fill in the prescribing physician's name on the line provided. This step is not necessary if the prescribing physician has signed the order. **Clinical Solutions cannot fill orders unless this information is provided.**