[insert practice name here]
Clinician Orders

PATIENT INFORMATION

1. LAST NAME	2. FIRST NAME	3. TODAY'S DATE __ __/__ __/__ __
4. DOB __ __/__ __/__ __	5. AGE (YEARS)	6. TIME __ __:__ __ (24hr)
7. GRAVIDITY	8. PARITY	

ALLERGIES

☐ No Known Allergies ☐ Yes (specify below)

ALLERGY	REACTION
_____	_____
_____	_____
_____	_____

BIRTH CONTROL

CONTRACEPTIVE METHOD	DISPENSED	RX	SCHEDULED
☐ Hormonal IUD OR ☐ Copper IUD, placed as directed	☐	☐	☐
☐ Ibuprofen 200 mg po x ___ for pain			
☐ Misoprostol 200 mg intravaginally			
☐ Misoprostol 200 mg buccally			
☐ Implant, subdermal, to be placed as directed	☐	☐	☐
☐ Pills: _____ as directed	☐	☐	☐
☐ DepoProvera 150 mg IM x 1 now, repeat Q 3 Months	☐	☐	☐
☐ NuvaRing	☐	☐	☐
☐ Ortho Evra Patch as directed	☐	☐	☐
☐ Other:_____	☐	☐	☐

STI TREATMENT

TREATMENT	DISPENSED	RX
☐ Azithromycin 1 gm po x 1 for chlamydia	☐	☐
☐ Doxycycline 100 mg po bid x 7 days for chlamydia	☐	☐
☐ Ceftriaxone 125 mg IM x 1 for gonorrhea	☐	☐
☐ Benzathine penicillin G 2.4 million units IM x 1 for syphilis	☐	☐
☐ Metronidazole 2 gm po x 1 for trichomoniasis	☐	☐
☐ Other*:_____	☐	☐

*Record medication, dose, route, and frequency.

OTHER PRESCRIPTIONS DISPENSED

PRESCRITION	DISPENSED	RX
☐ Metronidazole 500 mg po bid x 7 days for bacterial vaginosis	☐	☐
☐ Naprosyn 500 mg 1 bid prn	☐	☐
☐ Anaprox DS 1 bid prn	☐	☐
☐ Diflucan 150mg po x 1	☐	☐
☐ Other*:_____	☐	☐
☐ Other*:_____	☐	☐
☐ Other*:_____	☐	☐

*Record medication, dose, route, and frequency.

IF VERBAL SIGNATURE OBTAINED

Date Verbal Signature Obtained: __ __/__ __/__ __

Time Verbal Signature Obtained: __ __:__ __ (24 hr)

Clinician Providing Verbal Consent: _____ (Clinician Name)

Person Obtaining Verbal Consent: _____

CLINICIAN SIGNATURE

Clinician's Signature: _____

Date: __ __/__ __/__ __