FEDERAL OCCUPATIONAL HEALTH

Attachment E: Physician Treatment Orders - FOH–24 Form

ALL INFORMATION WILL BE CONSIDERED CONFIDENTIAL

Dear Doctor: If you are using this form for allergen immunotherapy, you must provide the information requested in blocks #1, 2, 3, 4, 5, 6, 7, 10, 11, and 12.

TO: **FOH Occupational Health Center Patient**

Health Unit Address Stamp Here:

Name:____

Diagnosis:______________________________________

Physician's Orders (may attach additional page):

1) Exact Name of Medication	2) Dosage	3) Interval of Administration
4) Method of Administration: ____ SQ ____ IM		5) Expiration Date of Order: (if less than 12 months)
6) First dose of each new multi-dose vial or box of single dose Should be given at: ____ Prescribing physician's office ____ FOH Occupational Health Center		
7a) Side effects/reactions anticipated 7b) Should the patient develop a reaction, carry out the following orders:		
8) Bedrest - Frequency and Duration (Please state reason on back of form. Important: Bedrest may not be available for more than 20 min/day).		
9) Other treatments and/or instructions - Frequency and Duration (Blood pressure, soaks and packs, dressing, etc.)		
10) Date Patient to return to my office:		11) Physician's Telephone ( ) ________________
12a) Physician's Signature: 12b) Printed Name		13) Date:
All physician treatment orders expire in 12 months		