995 Worthington Street, Springfield, MA 01109
Telephone 413-734-5376 FAX 413-737-7949

Mental Health Association, Inc.

Medication and Treatment Telephone / Facsimile Order Form

Date: _______________ Time: ________ am / pm

Site Address:_____________________ Phone:____________________ Fax:________________

Name: ________________________________ DOB: ____________ Allergies:__________________________

Name of MHA staff taking the order: ____

Name of prescriber authorizing the change: ____

Prescriber Phone#__________________________ Fax#_____________________

Medication Changes: (Please describe the changes ordered below)

Medication - Dosage - Route - Time of Administration (AM / PM)

____

____

____

____

____

____

____

____

Do all other medications remain the same? Yes ____ No ____

Was a copy of this telephone order sent to the psychiatrist/physician/nurse Yes ____ No ____

____________________________________MHA USE ONLY____________________________________

Posted By: ________________________________ **Date:** **Time** **am / pm**

Verified By: _______________________________ **Date:** **Time** **am / pm**

Signature of prescriber: ____ Date: ____________

Please sign and return within 72 hours

____________________________________MHA USE ONLY____________________________________

Posted By: ________________________________ **Date:** **Time** **am / pm**

Verified By: _______________________________ **Date:** **Time** **am / pm**