

Transcription Workbook One

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Dose = Strength x Amount Worksheet

DOSE is found in the Health Care Provider's order

HCP Order Example:

Health Care Provider Order	
Tina Lewis	no known allergies
Pepcid 20mg twice daily by mouth	
HCP's Signature: <i>Dr. Jones</i>	Date: 6/11/yr

(The dose is _____ mg)

STRENGTH is found on pharmacy label next to the name of the medication

Pharmacy Label Example:

Rx# 135	Greenleaf Pharmacy 20 Main Street Treetop, MA 00000	111-222-3434
Tina Lewis Famotidine 10mg I.C. Pepcid Take 2 tablets by mouth twice daily		6/11/yr
Qty. 120 Dr. Jones		
Lot# 323-5	ED: 6/11/yr	Refills: 3

(The strength is _____ mg)

AMOUNT is found on the pharmacy label in the instructions for administration

(The amount is _____ tabs)

PRACTICE SKILLS-TRANSCRIPTION

INSTRUCTIONS

You have taken Tina Lewis to the doctor and have received medication from the pharmacy. Pretend that the date is June 11, year. It is 1 pm.

Use the health care provider's order, pharmacy label and generic equivalents to discontinue the order and transcribe the new order on to the Medication Sheet.

Please Note: Do not place your initials in the medication box. You are not administering a medication at this time. This is transcription only.

HEALTH CARE PROVIDER ORDER

S
T
A
F
F

H
C
P

Name: Tina Lewis	Date: 6/11/yr
Health Care Provider: Dr. Jones	Allergies: no known allergies
Reason for Visit: Tina states she has a burning feeling in her throat during the day.	
Current Medications: Pantoprazole 40mg by mouth once daily in the evening	
Staff Signature: <i>John Smith, Program Manager</i>	Date: 6/11/yr
Health Care Provider Findings: GERD	
Medication/Treatment Orders:	
D/C Pantoprazole Pepcid 20mg <u>twice daily</u> by mouth	<div style="display: flex; justify-content: space-around; align-items: center;"> dosage frequency route </div>
Instructions:	
Follow-up visit:	Lab work or Tests:
Signature: <i>Dr. Jones</i>	Date: 6/11/yr

Month and Year: June (year)

MEDICATION ADMINISTRATION SHEET

Allergies: none

Start 2-7-yr	Generic Pantoprazole Brand Protonix Strength 40mg Amount 1 tab Frequency Once daily in the evening	Hour	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
Stop			
Cont.			

Special instructions:

Reason: decrease acid

Start	Generic Brand Strength Amount Frequency	Hour	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
Stop			

Special instructions:

Reason:

Start	Generic Brand Strength Amount Frequency	Hour	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
Stop			

Special instructions:

Reason:

Start	Generic Brand Strength Amount Frequency	Hour	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
Stop			

Special instructions:

Reason:

Name: Tina Lewis Site: Everett Street, Apt. 1A	CODES		CODES		Init	Signature
	DP-day program/day hab		A-Absent		JS	John Smith
	LOA-leave of absence		NSS-no second staff (e.g. Coumadin)		KB	Karl Burke
	P-packaged		OSA-off site administration		RN	Reggie Newton
	W-work		MNA-medication not administered		ST	Sarah Turney
	H-hospital, nursing home, rehab center		Signature			
	S-school					
	V-vacation					

Pharmacy Label

Rx#135	Greenleaf Pharmacy 20 Main Street Treetop, MA 00000	111-222-3434 6/11/yr
Tina Lewis		
Famotidine 10mg I.C. Pepcid	strength	Qty. 120
Take 2 tablets by mouth twice daily		Dr. Jones
<i>amount</i>		
Lot# 323-5	ED: 6/11/yr	Refills: 3

Generic Equivalents

Brand Name	Generic Equivalent
Pepcid	Famotidine
Loram	Loramine
Loxapril	Loxaprilline
Tylenol	Acetaminophen
Amoxil	Amoxicillin
EES	Erythromycin
Depakote	Divalproex
Haldol	Haloperidol
Tegretol	Carbamazepine
Pen VK	Penicillin

MEDICATION INFORMATION SHEET: SAMPLE ONLY

Pepcid is a stomach acid reducing medication used to treat and prevent ulcers, to treat GERD (gastro esophageal reflux disorder) and excessive acid secretion condition.

Month and Year: June (year)

MEDICATION ADMINISTRATION SHEET

Allergies: none

Special instructions:

Reason: reduce acid

Special instructions:

Reason: GFRD

Special instructions:

Reason:

Special instructions:

Reason:

Name: Tina Lewis Site: Everett Street, Apt. 1A	CODES	CODES	Init	Signature
	DP-day program/day hab	A-Absent	JS	<i>John Smith</i>
	LOA-leave of absence	NSS-no second staff (e.g. Coumadin)	KB	<i>Karl Burke</i>
	P-packaged	OSA-off site administration	RN	<i>Reggie Newton</i>
	W-work	MNA-medication not administered	ST	<i>Sarah Turney</i>
	H-hospital, nursing home, rehab center		Signature	
	S-school			
	V-vacation			

PRACTICE SKILLS-TRANSCRIPTION

INSTRUCTIONS

You have taken Tina Lewis to the doctor and have received medication from the pharmacy. Pretend that the date is June 20, year. It is 1 pm.

Use the health care provider's order, pharmacy label and generic equivalents to discontinue the order and transcribe the new orders on to the Medication Sheet.

Please Note: Do not place your initials in the medication box. You are not administering a medication at this time. This is transcription only.

HEALTH CARE PROVIDER ORDER

Name: Tina Lewis	Date: 6/20/yr
Health Care Provider: Dr. Smith	Allergies: None
Reason for Visit: complaint of pressure on forehead, mild fever, dizziness, increase in head slapping behavior	
Current Medications: Synthroid 0.125mg by mouth once a day in the morning	
Staff Signature: <i>Paula Jones, Program Manager</i>	Date: 6/20/yr
Health Care Provider Findings: hypothyroid, elevated blood pressure, sinus infection	
Medication/Treatment Orders: D/C Synthroid Armour Thyroid 30mg by mouth once daily before breakfast. Brand name only medication. Inderal 20mg by mouth once daily in the morning Amoxil 500mg by mouth three times daily for 10 days	
Instructions:	
Follow-up visit: 2 weeks	Lab work or Tests:
Signature: <i>Dr. Susan Smith</i>	Date: 6/20/yr

Month and Year: June (year)

MEDICATION ADMINISTRATION SHEET

Allergies: none

Start 3-23-yr	Generic Brand Synthroid Strength 0.125mg Dose 0.125mg	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
Stop	Amount 1 tab Route By mouth	8am JS KB JS JS JS RN RN RN JS ST JS JS RN RN RN JS JS JS JS
Cont.	Frequency Daily in the morning	

Special instructions:

Reason: replace thyroid hormone

Start	Generic Brand Strength Amount Frequency	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
Stop	Dose Route	

Special instructions:

Reason:

Start	Generic Brand Strength Amount Frequency	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
Stop	Dose Route	

Special instructions:

Reason:

Start	Generic Brand Strength Amount Frequency	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
Stop	Dose Route	

Special instructions:

Reason:

Name: Tina Lewis Site: Everett Street, Apt. 1A	CODES		CODES		Init	Signature
	DP-day program/day hab		A-Absent			
	LOA-leave of absence		NSS-no second staff (e.g. Coumadin)		JS	John Smith
	P-packaged		OSA-off site administration		KB	Karl Burke
	W-work		MNA-medication not administered		RN	Reggie Newton
	H-hospital, nursing home, rehab center		Signature		ST	Sarah Turney
	S-school					
	V-vacation					

Pharmacy Labels

Rx#139	Greenleaf Pharmacy 20 Main Street Treetop, MA 00000	111-222-3434
Tina Lewis Armour Thyroid 30mg I.C.	6/20/yr	Qty. 30
Take 1 tablet once daily before breakfast by mouth		
Dr. Smith		
Lot# 659	ED: 6/20/yr	Refills: 3

Rx#285-97226	Greenleaf Pharmacy 20 Main Street Treetop, MA 00000	111-222-3434
Tina Lewis Propranolol 10mg I.C. Inderal	6/20/yr	Qty. 60
Take 2 tablets once daily in the morning by mouth		
Dr. Smith		
Lot# 323-334	ED: 6/20/yr	Refills: 3

Rx#285-97227	Greenleaf Pharmacy 20 Main Street Treetop, MA 00000	111-222-3434
Tina Lewis Amoxicillin 500mg I.C. Amoxil	6/20/yr	Qty. 30
Take 1 tablet three times daily for ten days by mouth		
Dr. Smith		
Lot# 323-335	ED: 6/20/yr	Refills: 0

Generic Equivalents

Brand Name	Generic Equivalent
Dilantin	Phenytoin
Armour Thyroid	Thyroid desiccated
Inderal	Propranolol
Tylenol	Acetaminophen
Amoxil	Amoxicillin
EES	Erythromycin
Depakote	Divalproex
Haldol	Haloperidol
Tegretol	Carbamazepine
Pen VK	Penicillin

MEDICATION INFORMATION SHEET: SAMPLE ONLY

Armour Thyroid is a thyroid replacement medication used when the thyroid gland is not secreting enough thyroid hormone.

MEDICATION INFORMATION SHEET: SAMPLE ONLY

Inderal is a beta-blocker used to treat chest pain (angina), high blood pressure, irregular heartbeats, migraine headaches, tremors and other conditions as determined by your doctor. This medication has also been used for anxiety.

MEDICATION INFORMATION SHEET: SAMPLE ONLY

Amoxicillin is a commonly prescribed antibiotic. It is used to treat middle ear infections, sinusitis, and skin, respiratory tract and urinary tract infections caused by bacteria.

Month and Year: June (year)

MEDICATION ADMINISTRATION SHEET

Allergies: none

Special instructions:

Reason: replace thyroid hormone

Special instructions:

Reason: hypothyroid

Special instructions:

Reason: high blood pressure

Special instructions: For 10 days

Reason: sinus infection

Special Instructions: For 10 days	CODES	CODES	Init	Reason: sinus infection
Name: Tina Lewis	DP-day program/day hab	A-Absent	JS	John Smith
Site: Everett Street, Apt. 1A	LOA-leave of absence	NSS-no second staff (e.g. Coumadin)	KB	Karl Burke
	P-packaged	OSA-off site administration	RN	Reggie Newton
	W-work	MNA-medication not administered	ST	Sarah Turney
	H-hospital, nursing home, rehab center	Signature		
	S-school			
	V-vacation			

PRACTICE SKILLS-TRANSCRIPTION

INSTRUCTIONS

You have taken Jane McCarthy to the doctor and have received medication from the pharmacy. Pretend that the date is August 1, year. It is 2 pm.

Use the health care provider's order, pharmacy label and generic equivalents to discontinue the order and transcribe the new order on to the Medication Sheet.

Please Note: Do not place your initials in the medication box. You are not administering a medication at this time. This is transcription only.

HEALTH CARE PROVIDER ORDER

Name: Jane McCarthy	Date: 8/1/yr
Health Care Provider: Dr. White	Allergies: No Known Allergies
Reason for Visit: Continues to have frequent trips to bathroom during the night. Complains of a burning feeling when urinating.	
Current Medications: Cefaclor 250mg twice daily for seven days by mouth	
Staff Signature: <i>Paula Jones, Program Manager</i>	Date: 8/1/yr
Health Care Provider Findings: Urinary tract infection	
Medication/Treatment Orders: D/C Cefaclor Amoxil 500mg four times daily for 10 days by mouth	
Instructions:	
Follow-up visit:	Lab work or Tests:
Signature: <i>Andrea White, MD</i>	Date: 8/1/yr

Month and Year: August (year)

MEDICATION ADMINISTRATION SHEET

Allergies: none

Special instructions: For 7 days

Reason: urinary tract infection

Special instructions:

Reason:

Special instructions:

Reason:

Special instructions:

Reason:

Name:	Codes	Codes	Init	Signature
Name: Jane McCarthy	DP-day program/day hab	A-Absent	JS	<i>John Smith</i>
Site: 35 River Way	LOA-leave of absence	NSS-no second staff (e.g. Coumadin)		
	P-packaged	OSA-off site administration		
	W-work	MNA-medication not administered		
	H-hospital, nursing home, rehab center	Signature		
	S-school			
	V-vacation			

Pharmacy Label

Rx#276-97226	Greenleaf Pharmacy 20 Main Street Treetop, MA 00000	111-222-3434 8/1/yr
Jane McCarthy Amoxicillin 250mg I.C. Amoxil		Qty. 80
Take 2 capsules four times daily for 10 days by mouth		
Dr. A. White		
Lot# 323-336	ED: 8/1/yr	Refills: 0

Generic Equivalents

Brand Name	Generic Equivalent
Dilantin	Phenytoin
Loram	Loramine
Loxapril	Loxaprilline
Tylenol	Acetaminophen
Amoxil	Amoxicillin
EES	Erythromycin
Depakote	Divalproex
Haldol	Haloperidol
Tegretol	Carbamazepine
Pen VK	Penicillin

MEDICATION INFORMATION SHEET: SAMPLE ONLY

Amoxicillin

Common brand names are Amoxil, Polymox, Trimox and Wymox. Amoxicillin is a commonly prescribed antibiotic. It is used to treat middle ear infections, sinusitis, and skin, respiratory tract and urinary tract infections caused by bacteria.

Month and Year: August (year)

MEDICATION ADMINISTRATION SHEET

Allergies: none

Special instructions: **For 7 days**

Reason: urinary tract infection

Special instructions: For 10 days

Reason: urinary tract infection

Special instructions:

Reason:

Special instructions:

Reason:

Special Instructions:	Reason:			
	CODES	CODES	Init	Signature
Name: Jane McCarthy	<i>DP-day program/day hab</i>	A-Absent	JS	<i>John Smith</i>
Site: 35 River Way	<i>LOA-leave of absence</i>	NSS-no second staff (e.g. Coumadin)		
	<i>P-packaged</i>	OSA-off site administration		
	<i>W-work</i>	MNA-medication not administered		
	<i>H-hospital, nursing home, rehab center</i>	Signature		
	<i>S-school</i>			
	<i>V-vacation</i>			

PRACTICE SKILLS-TRANSCRIPTION

INSTRUCTIONS

You have taken Sam Lopes to the doctor and have received medication from the pharmacy. Pretend that the date is February 14, year. It is 3 pm.

Use the health care provider's order, pharmacy label and generic equivalents to discontinue the order and transcribe the new order on to the Medication Sheet.

Please Note: Do not place your initials in the medication box. You are not administering a medication at this time. This is transcription only.

HEALTH CARE PROVIDER ORDER

Name: Sam Lopes	Date: 2/14/yr
Health Care Provider: Dr. White	Allergies: No Known Allergies
Reason for Visit: Cough has worsened. Is now complaining of a sore throat.	
Current Medications: Amoxicillin 250mg four times daily for 5 days by mouth	
Staff Signature: <i>Paula Jones, Program Manager</i>	Date: 2/14/yr
Health Care Provider Findings: Upper respiratory infection	
Medication/Treatment Orders: D/C Amoxicillin EES 666mg three times daily for 5 days by mouth	
Instructions:	
Follow-up visit:	Lab work or Tests:
Signature: <i>Andrea White, MD</i>	Date: 2/14/yr

Month and Year: February (year)

MEDICATION ADMINISTRATION SHEET

Allergies: none

Start 2-12-yr	Generic Amoxicillin Brand Amoxil Strength 250mg Stop 2-17-yr	Dose 250mg Amount 1 tab Route By mouth Frequency Four times daily	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
			8am X X X X X X X X X X X X KBJS
			12pm X X X X X X X X X X X X X KB
			4pm X X X X X X X X X X X X RNST
			8pm X X X X X X X X X X X X RNST

Special instructions: For 5 days

Reason: respiratory infection

Start	Generic	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
	Brand	
	Strength	
	Dose	
Stop	Amount	
	Route	
	Frequency	

Special instructions:

Reason:

Start	Generic	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
	Brand	
	Strength	
	Dose	
Stop	Amount	
	Route	
	Frequency	

Special instructions:

Reason:

Start	Generic	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
	Brand	
	Strength	
	Dose	
Stop	Amount	
	Route	
	Frequency	

Special instructions:

Reason:

Name: Sam Lopes Site: 35 River Way	CODES						CODES						Init	Signature
	DP-day program/day hab						A-Absent							
	LOA-leave of absence						NSS-no second staff (e.g. Coumadin)						JS	John Smith
	P-packaged						OSA-off site administration						KB	Karl Burke
	W-work						MNA-medication not administered						RN	Reggie Newton
	H-hospital, nursing home, rehab center						Signature						ST	Sarah Turney
	S-school													
	V-vacation													

Pharmacy Label

Rx#277-97226	Greenleaf Pharmacy 20 Main Street Treetop, MA 00000	111-222-3434 2/14/yr
Sam Lopes Erythromycin 333mg I.C. EES		Qty. 30
Take 2 tablets three times daily for 5 days by mouth		
Dr. A. White		
Lot# 324-336	ED: 2/14/yr	Refills: 0

Generic Equivalents

Brand Name	Generic Equivalent
Dilantin	Phenytoin
Loram	Loramine
Loxapril	Loxaprilline
Tylenol	Acetaminophen
Amoxil	Amoxicillin
EES	Erythromycin
Depakote	Divalproex
Haldol	Haloperidol
Tegretol	Carbamazepine
Pen VK	Penicillin

MEDICATION INFORMATION SHEET: SAMPLE ONLY

Erythromycin

Erythromycin has many different brand names including Apo-Erythro, E-Base, EES, E-Mycin, Erybid, ERYC, Ery-Tab and PCE. Erythromycin is a commonly prescribed antibiotic used to treat a variety of infections including middle ear infections, sinusitis, sore throat, pneumonia, and skin, respiratory tract and urinary tract infections.

Month and Year: February (year)

MEDICATION ADMINISTRATION SHEET

Allergies: none

Start 2-12-yr	Generic Amoxicillin Brand Amoxil D/C 2-14-yr PJ Strength 250mg Dose 250mg	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
		8am X X X X X X X X X X X X KB JS
Stop	Amount 1 tab Route By mouth	12pm X X X X X X X X X X X X KB
2-17-yr	Frequency Four times daily	4pm X X X X X X X X X X X X RN ST
		8pm X X X X X X X X X X X X RN ST

Special instructions: **For 5 days**

Reason: respiratory infection

Special instructions: For 5 days

Reason: respiratory infection

Special instructions:

Reason:

Special instructions:

Reason:

Name:	Codes	Codes	Init	Signature
Name: Sam Lopes	DP-day program/day hab	A-Absent	JS	John Smith
Site: 35 River Way	LOA-leave of absence	NSS-no second staff (e.g. Coumadin)	KB	Karl Burke
	P-packaged	OSA-off site administration	RN	Reggie Newton
	W-work	MNA-medication not administered	ST	Sarah Turney
	H-hospital, nursing home, rehab center	Signature		
	S-school			
	V-vacation			

PRACTICE SKILLS-TRANSCRIPTION

INSTRUCTIONS

You have taken Joe Simon to the doctor and have received medication from the pharmacy. Pretend that the date is April 17, year. It is 2 pm.

Use the health care provider's order, pharmacy label and generic equivalents to discontinue the order and transcribe the new order on to the Medication Sheet.

Please Note: Do not place your initials in the medication box. You are not administering a medication at this time. This is transcription only.

HEALTH CARE PROVIDER ORDER

Name: Joe Simon	Date: 4/17/yr
Health Care Provider: Dr. Smith	Allergies: Sulfa drugs
Reason for Visit: Red area on left leg is getting larger despite doxycycline which was started 3 days ago.	
Current Medications: Doxycycline 100mg once daily in the morning for ten days by mouth	
Staff Signature: <i>Paula Jones, Program Manager</i>	Date: 4/17/yr
Health Care Provider Findings: Cellulitis left leg	
Medication/Treatment Orders: D/C Vibramycin Keflex 500mg twice daily for 10 days by mouth Prednisone 5mg by mouth once daily at 4pm for three days, to decrease inflammation	
Instructions:	
Follow-up visit:	Lab work or Tests:
Signature: <i>Donald Smith, MD</i>	Date: 4/17/yr

Month and Year: April (year)

MEDICATION ADMINISTRATION SHEET

Allergies: Sulfa Drugs

Special instructions: For ten days

Reason: Cellulitis left leg

Special instructions:

Reason:

Special instructions:

Reason:

Special instructions:

Reason:

	CODES	CODES	Init	Signature
Name: Joe Simon	<i>DP-day program/day hab</i>	A-Absent	JS	<i>John Smith</i>
Site: 35 River Way	<i>LOA-leave of absence</i>	NSS-no second staff (e.g. Coumadin)	KB	<i>Karl Burke</i>
	<i>P-packaged</i>	OSA-off site administration		
	<i>W-work</i>	MNA-medication not administered		
	<i>H-hospital, nursing home, rehab center</i>		Signature	
	<i>S-school</i>			
	<i>V-vacation</i>			

Pharmacy Labels

Rx#287-97226	Greenleaf Pharmacy 20 Main Street Treetop, MA 00000	111-222-3434
Joe Simon Cephalexin 250mg I.C. Keflex		4/17/yr
Take 2 tablets twice daily for ten days by mouth		Qty: 40
		Dr. Smith
Lot# 324-331	ED: 4/17/yr	Refills: 0

Rx#283-97225	Greenleaf Pharmacy 20 Main Street Treetop, MA 00000	111-222-3434
Joe Simon Prednisone 5mg I.C.		4/17/yr
Take 1 tablet once daily at 4 pm for three days by mouth		Qty: 3
		Dr. Smith
Lot# 676-009	ED: 4/17/yr	Refills: 0

Generic Equivalents

Brand Name	Generic Equivalent
Keflex	Cephalexin
Loram	Loramine
Sterapred	Prednisone
Tylenol	Acetaminophen

MEDICATION INFORMATION SHEET: SAMPLE ONLY

Cephalexin
Brand name for Cephalexin is Keflex. Cephalosporin antibiotic commonly used to treat bacterial infections in the body.

Prednisone
Prednisone is a corticosteroid that prevents the release of substances in the body which cause inflammation.

Month and Year: April (year)

MEDICATION ADMINISTRATION SHEET

Allergies: Sulfa Drugs

Start 4-15-yr	Generic Doxycycline Brand Vibramycin D/C 4-17-yr PJ	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
	Strength 100mg Dose 100mg	8am X X X X X X X X X X X X X X KBKBJS
Stop 4-24-yr	Amount 1 tab Route By mouth	
	Frequency Once daily in the morning	D/C 4-17-yr PJ

Special instructions: For ten days

Reason: Cellulitis left leg

Special instructions: For ten days

Reason: Cellulitis left leg

Special instructions:

Reason Decrease inflammation

Special instructions:

Reason:

	CODES	CODES	Init	Signature
Name: Joe Simon	<i>DP-day program/day hab</i>	A-Absent	JS	<i>John Smith</i>
Site: 35 River Way	<i>LOA-leave of absence</i>	NSS-no second staff (e.g. Coumadin)	KB	<i>Karl Burke</i>
	<i>P-packaged</i>	OSA-off site administration		
	<i>W-work</i>	MNA-medication not administered		
	<i>H-hospital, nursing home, rehab center</i>		Signature	
	<i>S-school</i>			
	<i>V-vacation</i>			

PRACTICE SKILLS-TRANSCRIPTION

INSTRUCTIONS

You have taken Casey Forte to the doctor and have received medication from the pharmacy. Pretend that the date is May 20, year. It is 1 pm.

Use the health care provider's order, pharmacy label and generic equivalents to discontinue the order and transcribe the new order on to the Medication Sheet.

Please Note: Do not place your initials in the medication box. You are not administering a medication at this time. This is transcription only.

HEALTH CARE PROVIDER ORDER

Name: Casey Forte	Date: 5/20/yr
Health Care Provider: Dr. Smith	Allergies: No Known Allergies
Reason for Visit: Frowning and asking for second cup of water when swallowing Amoxicillin in tablet form started last night.	
Current Medications: Amoxicillin 250mg four times daily for 7 days by mouth	
Staff Signature: <i>Paula Jones, Program Manager</i>	Date: 5/20/yr
Health Care Provider Findings: UTI, difficulty swallowing tablets, will try medication in suspension form	
Medication/Treatment Orders: D/C Amoxicillin Amoxil suspension 250mg four times daily for 10 days by mouth	
Instructions:	
Follow-up visit:	Lab work or Tests:
Signature: <i>Donald Smith, MD</i>	Date: 5/20/yr

Month and Year: May (year)

MEDICATION ADMINISTRATION SHEET

Allergies: none

Special instructions: **For 7 days**

Reason: urinary tract infection

Special instructions:

Reason:

Special instructions:

Reason:

Special instructions:

Reason:

	CODES	CODES	Init	Signature
Name: Casey Forte	<i>DP-day program/day hab</i>	A-Absent	JS	<i>John Smith</i>
Site: 35 River Way	<i>LOA-leave of absence</i>	NSS-no second staff (e.g. Coumadin)	KB	<i>Karl Burke</i>
	<i>P-packaged</i>	OSA-off site administration	RN	<i>Reggie Newton</i>
	<i>W-work</i>	MNA-medication not administered		
	<i>H-hospital, nursing home, rehab center</i>	Signature		
	<i>S-school</i>			
	<i>V-vacation</i>			

Pharmacy Label

Rx#287-97326	Greenleaf Pharmacy 20 Main Street Treetop, MA 00000	111-222-3434 5/20/yr
Casey Forte Amoxicillin Suspension 250mg per 5mL I.C. Amoxil suspension		Qty: 200mL
Take 5mL four times daily for 10 days by mouth		Dr. Smith
Lot# 324-231	ED: 5/20/yr	Refills: 0

Generic Equivalents

Brand Name	Generic Equivalent
Dilantin	Phenytoin
Loram	Loramine
Loxapril	Loxaprilline
Tylenol	Acetaminophen
Amoxil suspension	Amoxicillin suspension
EES	Erythromycin
Depakote	Divalproex
Haldol	Haloperidol
Tegretol	Carbamazepine
Pen VK	Penicillin

MEDICATION INFORMATION SHEET: SAMPLE ONLY

Amoxicillin

Common brand names are Amoxil, Polymox, Trimox and Wymox. Amoxicillin is a commonly prescribed antibiotic. It is used to treat middle ear infections, sinusitis, and skin, respiratory tract and urinary tract infections caused by bacteria.

Month and Year: May (year)

MEDICATION ADMINISTRATION SHEET

Allergies: none

Start 5-19-yr	Generic Amoxicillin Brand Amoxil D/C 5-20-yr PJ Strength 250mg Dose 250mg	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
		8am X X X X X X X X X X X X X X X X X X KB
		12pm X X X X X X X X X X X X X X X X X X JS
		4pm X X X X X X X X X X X X X X X X X X
Stop 5-27-yr	Amount 1 tab Route By mouth Frequency Four times daily	8pm X X X X X X X X X X X X X X X X X X RN

Special instructions: **For 7 days**

Start 5-20-yr	Generic Amoxicillin suspension Brand Amoxil suspension Strength 250mg/ 5mL Dose 250mg	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
		8am X X X X X X X X X X X X X X X X X X
		12pm X X X X X X X X X X X X X X X X X X
		4pm X X X X X X X X X X X X X X X X X X
Stop 5-30-yr	Amount 5mL Route By mouth Frequency Four times daily	8pm X X X X X X X X X X X X X X X X X X

Special instructions: **For 10 days**Reason: **urinary tract infection**

Start	Generic Brand Strength Amount Frequency	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
Stop		

Special instructions:

Reason:

Start	Generic Brand Strength Amount Frequency	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
Stop		

Special instructions:

Reason:

Name: Casey Forte Site: 35 River Way	CODES							CODES							Init	Signature		
	DP-day program/day hab							A-Absent										
	LOA-leave of absence							NSS-no second staff (e.g. Coumadin)										
	P-packaged							OSA-off site administration										
	W-work							MNA-medication not administered										
	H-hospital, nursing home, rehab center							Signature										
	S-school																	
V-vacation																		

PRACTICE SKILLS-TRANSCRIPTION

INSTRUCTIONS

You have taken Marie Sousa to the doctor and have received medication from the pharmacy. Pretend that the date is August 5, year. It is 1 pm.

Use the health care provider's order, pharmacy label and generic equivalents to discontinue the order and transcribe the new order on to the Medication Sheet.

Please Note: Do not place your initials in the medication box. You are not administering a medication at this time. This is transcription only.

HEALTH CARE PROVIDER ORDER

Name: Marie Sousa	Date: 8/5/yr
Health Care Provider: Dr. Smith	Allergies: No Known Allergies
Reason for Visit: Marie complains of pain in her stomach after eating	
Current Medications: Prilosec 20mg by mouth once daily in the morning for 14 days	
Staff Signature: <i>Paula Jones, Program Manager</i>	Date: 8/5/yr
Health Care Provider Findings: Gastritis, will try a trial of Carafate	
Medication/Treatment Orders: D/C Prilosec Carafate suspension 1GM by mouth three times daily one hour before meals for seven days	
Instructions:	
Follow-up visit:	Lab work or Tests:
Signature: <i>Donald Smith, MD</i>	Date: 8/5/yr

Month and Year: August (year)

MEDICATION ADMINISTRATION SHEET

Allergies: none

Special instructions: For 14 days

Reason: Gastritis

Special instructions:

Reason:

Special instructions:

Reason:

Special instructions:

Reason:

	CODES	CODES	Init	Signature
Name: Marie Sousa	<i>DP-day program/day hab</i>	A-Absent	JS	<i>John Smith</i>
Site: 35 River Way	<i>LOA-leave of absence</i>	NSS-no second staff (e.g. Coumadin)	KB	<i>Karl Burke</i>
	<i>P-packaged</i>	OSA-off site administration	RN	<i>Reggie Newton</i>
	<i>W-work</i>	MNA-medication not administered		
	<i>H-hospital, nursing home, rehab center</i>	Signature		
	<i>S-school</i>			
	<i>V-vacation</i>			

Pharmacy Label

Rx#287-96326	Greenleaf Pharmacy 20 Main Street Treetop, MA 00000	111-222-3434 8/5/yr
Marie Sousa Sucralfate suspension 1GM/10mL I.C. Carafate suspension		Qty: 210mL
		Dr. Smith
Take 10mL three times daily one hour before meals for seven days by mouth		
Lot# 314-231	ED: 8/5/yr	Refills: 0

Generic Equivalents

Brand Name	Generic Equivalent
Carafate suspension	Sucralfate suspension
Loram	Loramine
Loxapril	Loxaprilline
Tylenol	Acetaminophen
Amoxil	Amoxicillin
EES	Erythromycin
Depakote	Divalproex
Haldol	Haloperidol
Tegretol	Carbamazepine
Pen VK	Penicillin

MEDICATION INFORMATION SHEET: SAMPLE ONLY

Sucralfate

Sucralfate, also known by the brand name Carafate is an anti-ulcerative medication used to treat and prevent ulcers in the stomach.

Month and Year: August (year)

MEDICATION ADMINISTRATION SHEET

Allergies: none

Special instructions: **For 14 days**

Reason: gastritis

Special instructions: before meals for 7 days

Reason: gastritis

Special instructions:

Reason:

Special instructions:

Reason:

Special Instructions:		Reason:		
Name:	Codes	Codes	Init	Signature
Name: Marie Sousa	DP-day program/day hab	A-Absent	JS	<i>John Smith</i>
Site: 35 River Way	LOA-leave of absence	NSS-no second staff (e.g. Coumadin)	KB	<i>Karl Burke</i>
	P-packaged	OSA-off site administration	RN	<i>Reggie Newton</i>
	W-work	MNA-medication not administered		
	H-hospital, nursing home, rehab center		Signature	
	S-school			
	V-vacation			

PRACTICE SKILLS-TRANSCRIPTION

INSTRUCTIONS

You have taken Chris Star to the doctor and have received medication from the pharmacy. Pretend that the date is September 16, year. It is 3 pm.

Use the health care provider's order, pharmacy label and generic equivalents to transcribe the new order on to the Medication Sheet.

Please Note: Do not place your initials in the medication box. You are not administering a medication at this time. This is transcription only.

HEALTH CARE PROVIDER ORDER

Name: Chris Star	Date: 9/16/yr
Health Care Provider: Dr. Smith	Allergies: no known allergies
Reason for Visit: Has had a cough for the past 24 hours. Temperature was 97.4 degrees by mouth this morning.	
Current Medications: none	
Staff Signature: <i>John Smith, Program Manager</i>	Date: 9/16/yr
Health Care Provider Findings: Bronchitis	
Medication/Treatment Orders: Centrex liquid 120mg twice daily for 5 days by mouth	
Instructions:	
Follow-up visit:	Lab work or Tests:
Signature: <i>David Smith, MD</i>	Date: 9/16/yr

Month and Year: September (year)

MEDICATION ADMINISTRATION SHEET

Allergies: none

Start	Generic	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Brand																																
	Strength	Dose																															
Stop	Amount	Route																															
	Frequency																																

Special instructions:

Reason:

Start	Generic	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Brand																																
	Strength	Dose																															
Stop	Amount	Route																															
	Frequency																																

Special instructions:

Reason:

Start	Generic	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Brand																																
	Strength	Dose																															
Stop	Amount	Route																															
	Frequency																																

Special instructions:

Reason:

Start	Generic	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Brand																																
	Strength	Dose																															
Stop	Amount	Route																															
	Frequency																																

Special instructions:

Reason:

Name:	Site:	CODES		CODES		Init	Signature
		DP-day program/day hab	A-Absent	LOA-leave of absence	NSS-no second staff (e.g. Coumadin)		
Chris Star	35 River Way	P-packaged	OSA-off site administration	W-work	MNA-medication not administered		
		H-hospital, nursing home, rehab center			Signature		
		S-school					
		V-vacation					

Pharmacy Label

Rx#284-87226	Greenleaf Pharmacy 20 Main Street Treetop, MA 00000	111-222-3434 9/16/yr
Chris Star Centromonium 60mg/3mL I.C. Centrex	Qty: 60mL	
Give 6mL twice daily (special dropper) by mouth for 5 days		
Dr. D. Smith		
Lot# 323-233	ED: 9/16/yr	Refills: 0

Generic Equivalents

Brand Name	Generic Equivalent
Dilantin	Phenytoin
Loram	Loramine
Loxapril	Loxaprilline
Tylenol	Acetaminophen
Amoxil	Amoxicillin
EES	Erythromycin
Depakote	Divalproex
Centrex	Centromonium
Tegretol	Carbamazepine
Pen VK	Penicillin

MEDICATION INFORMATION SHEET: SAMPLE ONLY

Centromonium

Centromonium (brand name: Centrex) may be prescribed to help relieve your cough by loosening mucus or phlegm in your lungs. It's helpful for coughs due to colds but not for long-term coughs such as those associated with asthma, emphysema or smoking.

Month and Year: September (year)

MEDICATION ADMINISTRATION SHEET

Allergies: none

Special instructions: **For 5 days**

Use special dropper

Reason: Bronchitis

Special instructions:

Reason:

Special instructions:

Reason:

Special instructions:

Reason:

Name: Chris Star Site: 35 River Way	CODES	CODES	Init	Signature
	<i>DP-day program/day hab</i>	A-Absent		
	<i>LOA-leave of absence</i>	NSS-no second staff (e.g. Coumadin)		
	<i>P-packaged</i>	OSA-off site administration		
	<i>W-work</i>	MNA-medication not administered		
	H-hospital, nursing home, rehab center	Signature		
	S-school			
	V-vacation			