

CLIENT TREATMENT ORDERS

Name:		PARIS ID:	
DOB:	Age:	PHN:	
Gender:		Phone:	
Address:		GP:	GP Phone:

Pharmacies - Current

Pharmacy	Address	Phone/Fax
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Allergies - Current

A / S	Date Entered	Allergen	Reaction	Comment
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Treatment Directives

Treatment Order: End Date: Authorised Prescriber:

Verbal/Telephone Order: Order Request Faxed: Confirmed(Written Order Received):

Comments:

Treatment Order: End Date: Authorised Prescriber:

Verbal/Telephone Order: Order Request Faxed: Confirmed(Written Order Received):

Comments:

Note: Once downtime information from this form has been entered in PARIS, shred this working sheet.

----- End of Report -----