

Coastal Behavior Health Services, Inc.  
P.O. Box 58424  
Fayetteville, N.C. 28305

NC Division of Mental Health  
Developmental Disabilities and  
Substance Abuse Services

<b>CLIENT:</b>	<b>All orders must be signed by a physician. Date, sign and authenticate.</b>
<b>RECORD NUMBER:</b>	

<b>ALLERGIES (FOOD, DRUG, ETC):</b>	<b>PHARMACY NAME:</b>
	<b>PHONE NUMBER:</b>

DATE	MEDICATION NAME, STRENGTH, ADMINISTRATION DIRECTIONS, ETC.	ACTIVE	INACTIVE	DATE	MEDICATION NAME, STRENGTH, ADMINISTRATION DIRECTIONS, ETC.	ACTIVE	INACTIVE

**PRESCRIBED MEDICATION:** List all medication prescribed by area program (e.g. regular prescriptions, either written or phoned in, orders for injectable medications and “stat” orders). Please indicate if order phoned in. Quantity prescribed should coincide with return appointment. Check in “Med. Ed. Doc.” Column when Medication Education is documented in record. Discontinued medication should be dated in “D/C Date” column. Update during course of therapy as needed.

DATE	MEDICATION NAME	STRENGTH	ADMINISTRATION DIRECTIONS	QUANTITY PRESCRIBED	# RE-FILL	MED. ED. DOC.	PHYSICIAN'S SIGNATURE	D/C DATE