Name of Medication	Dose & Frequency	Continue use after discharge
		YES or NO
		YES or NO
		YES or NO
		YES or NO
		YES or NO
		YES or NO
		YES or NO
		YES or NO
		YES or NO
		YES or NO
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		YES or NO
		YES or NO
		YES or NO
		YES or NO
		YES or NO
		YES or NO
		YES or NO
		YES or NO
		YES or NO
		YES or NO
		YES or NO
		YES or NO
		YES or NO
		YES or NO
		YES or NO
		YES or NO
		YES or NO
		YES or NO
Continue the use of all the above medications		YES or NO

Other medication orders

PHYSICIAN SIGNATURE

DATE

Patient's Name	Physician