



108 N. Main St. / P.O.Box 1121, Reidsville, North Carolina 27320  
Phone: (336) 342-9504, menu option 4 Fax: (336) 342-9506 Web: [www.remmSCO.org](http://www.remmSCO.org)

### Physician's Statement

Physician/Nurse name: \_\_\_\_\_ Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

I have examined this patient and found that he is stable physically and emotionally and able to fully participate in the program at REMMSCO, Inc. This person is expected to comply with the following physician's order for prescription medications. The patient has been advised of the benefits and possible adverse effects of these medications through my office.

**The patient may also use OTC drugs approved for use in the REMMSCO houses including the following as-needed.** We may ask the patient to discuss use with a physician if using for more than 2 weeks. I understand that prescription and OTC medications and supplements at 108 N Main are stored securely and given to the resident, with staff supervision, at times the medication is scheduled for administration. I agree this patient may self-administer medications while on passes approved by the REMMSCO staff.

Acetaminophen up to 1000mg TID po prn	Allegra/Fexofenadine HCl 180mg prn, Claritin/Loratadine 10mg QD prn
Ibuprofen, Advil, Motrin, any NSAID up to two 200mg tab TID prn	Diphenhydramine HCl 25mg TID prn
Mucinex/Guaifenesin up to 400mg QID prn	Hydrocortisone cream 1% QID top prn
Pepto-Bismol/Bismuth Subsalicylate up to 525mg q30m prn	Colace/Docusate sodium 100mg as directed.
Tums/Calcium Carbonate antacid tablets 2-3g up to 7g QD prn	Sunscreen, insect repellent, saline nasal spray as directed.
Imodium/Loperamide Hydrochloride 2mg up to QID prn	Nicotine gum, lozenges, or patches as directed.
Xyzal/Levocetirizine 5mg QD prn, Zyrtec/Cetirizine HCl 10mg QD prn	Multivitamin as directed.

### **NO Opiates, Narcotics, Benzodiazepines, or Amphetamines**

Name of medication (print)	Dose	How often	Route
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_