REMMSCO
Substance Abuse Recovery Homes

108 N. Main St. / P.O.Box 1121, Reidsville, North Carolina 27320
Phone: (336) 280-0371 Fax: (336) 342-9506 Web: 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 patient is expected to comply with the following physician's order for medications. He has been advised of the benefits and possible adverse effects of these medications through my office. I understand that prescription and OTC medications and supplements 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, and may self-administer and carry albuterol and levalbuterol rescue inhalers on their person if they have been prescribed.

The patient may also use the following OTC medications in the REMMSCO houses as-needed per box directions. We may ask the patient to discuss use with a physician if using an OTC medication for more than 2 weeks.

Multivitamin	Imodium/Loperamide HCl	Allegra/Fexofenadine
Acetaminophen/Tylenol	Colace stool softener/Docusate sodium	Claritin/Loratadine
Ibuprofen, Advil, Motrin, any NSAID	Magnesium Hydroxide (Milk of Magnesia)	Benadryl/Diphenhydramine HCl (alcohol-free)
Mucinex/Guaifenesin	Xyzal/Levocetirizine	Hydrocortisone cream
Pepto-Bismol/Bismuth Subsalicylate	Zyrtec/Cetirizine HCl	Nicotine gum, lozenges, or patches
Tums/Calcium Carbonate antacid		

NO Opiates, Narcotics, Benzodiazepines, or Amphetamines

Medication, instructions (dose, frequency, route)	**Condition this medication is treating**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Prescriber Signature: _____ **Date:** _____