



Patient Medication Form (PORS)

Patient Name: _____ **Patient Date of Birth:** _____

Please list current medications below. Include **prescription, over-the-counter, herbals, or vitamins/minerals/nutritional supplements**. If further space is needed, please use the back.

FORM MUST BE COMPLETED IN ITS ENTIRETY AS PER INSURANCE REQUIREMENTS

Medication Name	Dosage & Frequency	Delivery Method (Oral, Patch, Topical, Nasal, Inhaler, Drops, Suppository)	Indication (Reason Used)	For updates only: Added ^{And/} Or Removed & Date

PATIENT SIGNATURE: _____

REVIEWED BY: _____

Date: _____

Date : _____

UPDATES: Initial and Date: _____

UPDATES: Initial and Date: _____

UPDATES: Initial and Date: _____

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