## *RONAI Physical Therapy & Sports Medicine*
### *MEDICATION LIST*

Patient Name: ______________________________
Patient DOB: ________________________
Date of Eval: _________________________

**ROUTE METHODS**

**ID = INTRADERMAL (UNDER SKIN)**
**IM = INTRAMUSCULAR**
**IV = INTRAVENOUS**
**PO = BY MOUTH**
**PR = BY RECTUM**
**SUBQ = UNDERSKIN**
**SL = UNDER THE TONGUE**
**SUPP = SUPPOSITORY**
**RIGHT EYE = (no abbreviation)**
**LEFT EYE = (no abbreviation)**

**FREQUENCY TYPES**

**AC = BEFORE MEALS**
**PC = AFTER MEAL**
**PRN = WHEN NECESSARY**
**EVERYDAY = (no abbreviation)**
**EVERY OTHER DAY = (no abbreviation)**
**EVERY HOUR = (no abbreviation)**
**2X/DAY = (no abbreviation)**
**3X/DAY = (no abbreviation)**

| Medication | Prescribing MD | Dosage | Frequency | Route | ***OFFICE USE*** Modifications while on program |
|---|---|---|---|---|---|
| 1. | | | | | ○ Add _______ ○ Stopped taking ____<br>○ Modification as noted ______________<br>○ Therapist Initials/Date: ____________ |
| 2. | | | | | ○ Add _______ ○ Stopped taking ____<br>○ Modification as noted ______________<br>○ Therapist Initials/Date: ____________ |
| 3. | | | | | ○ Add _______ ○ Stopped taking ____<br>○ Modification as noted ______________<br>○ Therapist Initials/Date: ____________ |
| 4. | | | | | ○ Add _______ ○ Stopped taking ____<br>○ Modification as noted ______________<br>○ Therapist Initials/Date: ____________ |
| 5. | | | | | ○ Add _______ ○ Stopped taking ____<br>○ Modification as noted ______________<br>○ Therapist Initials/Date: ____________ |
| 6. | | | | | ○ Add _______ ○ Stopped taking ____<br>○ Modification as noted ______________<br>○ Therapist Initials/Date: ____________ |
| 7. | | | | | ○ Add _______ ○ Stopped taking ____<br>○ Modification as noted ______________<br>○ Therapist Initials/Date: ____________ |
| 8. | | | | | ○ Add _______ ○ Stopped taking ____<br>○ Modification as noted ______________<br>○ Therapist Initials/Date: ____________ |

Therapist Initials: ______ Therapist Signature: ____________________________

Therapist Initials: ______ Therapist Signature: ____________________________