Providence Health Care SPH

DISCHARGE PRESCRIPTION

[redacted]
Birth Date: [redacted]

PHN: [redacted]

Allergies: **No Known Allergy**

Community Pharmacy: _____

Phone: _____

Fax: _____

Patient Address: [redacted]

Medication	Start/Stop	Continue (circle Yes/No)	New Dose/Directions (include dosage and frequency)	Qty	Duration (Days)	Refill
GlyBURIDE Tab 5 mg 5 mg (1 tab) po bid (Take with food)	27Feb2009 25Feb2019	Yes or No				
Betamethasone Cream 0.05% (Bulk) Apply bid prn to affected area of left leg	25Feb2009 23Feb2019	Yes or No				
Tamsulosin SR Cap 0.4 mg 0.4 mg (1 cap) po hs (Take 30 minutes after meal) Do not chew, crush, or open capsules	25Feb2009 23Feb2019	Yes or No				

Additional Medications:

Please circle applicable packing option: Safety vials / Blister packaging / Non-safety vials / Other _____

MD: _____ **CPSBC #:** _____ **Date:** _____

PLEASE GIVE THIS PRESCRIPTION TO THE PATIENT TO BE FILLED AT A COMMUNITY PHARMACY

Date Printed: 01Mar2009 1140