United Support Services, Inc.

"The works of many coming together for the good of One"

Physician's Order Form

Member's Name:	Member's Medicaid #:
Member's DOB:	Member's Record #:

Medication	Dosage	Instructions

Doctor's Name (Print Name):	Phone Number:
Address:	Fax Number:

This patient and/or patient's guardian has received ☐ written/ ☐ oral information from me (or my assistant) about the purpose of these medications and their potential side effects.

Physician's Signature: Date: