



FEDERAL OCCUPATIONAL HEALTH

Attachment E: Physician Treatment Orders - FOH-24 Form (formerly 229-B)

ALL INFORMATION WILL BE CONSIDERED CONFIDENTIAL

Dear Doctor: If you are using this form for allergen immunotherapy, you must provide the information requested in blocks #1, 2, 3, 4, 5, 6, 7, 10, 11, and 12.

TO: FOH Occupational Health Center Patient

Health Unit Address Stamp Here:

Name: _____

Diagnosis: _____

Physician's Orders (may attach additional page):

1) Exact Name of Medication	2) Dosage	3) Interval of Administration
4) Method of Administration: ___ SQ ___ IM		5) Expiration Date of Order: (if less than 6 months)
6) First dose of each new multi-dose vial or box of single dose Should be given at: ___ Prescribing physician's office ___ FOH Occupational Health Center		
7a) Side effects/reactions anticipated		
7b) Should the patient develop a reaction, carry out the following orders:		
8) Bedrest - Frequency and Duration (Please state reason on back of form. <u>Important:</u> Bedrest may not be available for more than 20 min/day).		
9) Other treatments and/or instructions - Frequency and Duration (Blood pressure, soaks and packs, dressing, etc.)		
10) Date Patient to return to my office:	11) Physician's Telephone () _____	
12a) Physician's Signature:	13) Date:	
12b) Printed Name		
All physician treatment orders expire in 6 months		