

**Community Memorial Hospital**

*Proud Partners with Allen Memorial Hospital*

909 W 1st Street P.O. Box 148

Sumner, Iowa 50674

Ph: (563)578-3275

**DISCHARGE MEDICATION SHEET**

PT Name: CPSI TEST PATIENT

MR #: 999999

Account #: CPSI02

Date: DOB: 05051972

Provider:

COMPLETED BY:

ALLERGIES: PCN

MEDICATION LIST:	LAST TAKEN	7 AM	8 AM	12 PM	6 PM	8 PM	AS NEEDED
LASIX 40MG WHY: WATER PILL	2/27/08	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WHY:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WHY:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WHY:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WHY:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WHY:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WHY:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WHY:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>