TELEPHONE ORDER/VERBAL ORDER

PATIENT'S NAME	[Medical Record Label]	
ID #	HEALTH DEPARTMENT	
	[ ]	
Signature/Title of Health Professional Receiving Order	Date	Time
ORDERS:		
Physician or Other Authorized Provider: (Please Print)	MD/Provider Address	
Signature/Title of Physician or Other Authorized Provider	Date	Time

Sign original and return to Health Department. The Health Department keeps the copy until the original is returned. **HHS-117 (Rev. 12/06)**