



WESTCHESTER VILLA
SENIOR ASSISTED LIVING COMMUNITY

INITIAL MEDICATION VERIFICATION

Dear Dr. _____:

RE: Your Patient: _____

is a resident of Westchester Villa, a Licensed Residential Care Facility for the Elderly (RCFE).

In order to comply with the State Regulations, we need a list and verification of your patient's medication orders. **Due to State Regulations, orders cannot include parameters for Medication Technicians to hold medications based on vital signs (e.g. Hold if Pulse < 60, Hold if Systolic BP <100).**

MEDICATION	DIRECTIONS

Physician's Signature _____

Date _____

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