Facility:	Address:
Phone:	Fax:

PRN AUTHORIZATION LETTER

Dear Dr. ______________________________,

Your patient,____, is a resident in our facility.

To receive nonprescription and prescription PRN medications, State Licensing requires that either
1) your patient be capable of determining his/her own need for the medication, **OR**
2) for nonprescription medication only, be able to clearly communicate his/her symptoms.

If your patient cannot determine his/her need for a medication, or clearly communicate the symptoms for a nonprescription medication, then you, the physician, must be contacted before the PRN medication can be given. Your completion of this form will serve to document your patient's current ability to determine his/her own need for these medications.

As a licensed care provider, it is my responsibility to monitor your patient's continued ability to determine his/her own need for PRN medications and inform you of any changes which indicate he/she can no longer make these decisions.

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Please check which circumstance describes your patient:

___My patient can determine and clearly communicate his/her need for prescription and nonprescription medication on a PRN basis.

___My patient cannot determine his/her own need for nonprescription PRN medication, but can clearly communicate his/her symptoms indicating a need for a nonprescription medication.

___My patient cannot determine his/her need for prescription and/or nonprescription PRN medication and cannot clearly communicate his/her symptoms indicating a need for a nonprescription PRN medication. **(Licensee must contact physician before each dose)**

The following prescription and nonprescription medication can be taken by this patient on a PRN basis:

________________________ ________________________ ____________________________

________________________ ________________________ ____________________________

. **Physician's Signature: ____________________________________ Date: ____________________**