PRN Authorization Letter

Dear Dr. _____,

Re: Your Patient: _____ D.O.B.: _____

To receive non-prescription 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 non-prescription 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 non-prescription 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.

Thank you for your assistance.

Sincerely,

Signature: _____ Title: _____

Phone Number: _____ Date: _____

Please check which circumstance describes your patient:

☐ My patient can determine and clearly communicate his/her need for prescription and/or non-prescription PRN medication.

☐ My patient cannot determine his/her own need for prescription and/or non-prescription PRN medications but can clearly communicate his/her symptoms indicating a need for prescription and/or non-prescription PRN medications.

☐ My patient cannot determine his/her own need for prescription and/or non-prescription PRN medications and cannot clearly communicate his/her symptoms indicating a need for prescription and/or non-prescription PRN medications. (Licensee must contact physician before each dose.)

The following prescription and non-prescription medications can be taken by this patient on a PRN basis:

_____ _____

_____ _____

_____ _____

Physician's Signature: _____ Date: _____