

**PRN Authorization Letter**

**Date:**

**Dear Dr.**

**Re: Your Patient:**

**A Client of :**

To receive nonprescription and prescription PRN medications, state licensing requires that either:

1. Your patient be capable of determining his/her own need for 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.

Thank you for your assistance

Signature: \_\_\_\_\_ Title: \_\_\_\_\_

Facility Telephone No.: \_\_\_\_\_ Facility Fax No.: \_\_\_\_\_

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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 prescription and nonprescription PRN medication, but can clearly communicate his/her symptoms indicating a need for a nonprescription medication.
- My patient cannot determine his/her own need for prescription and nonprescription PRN medication, and cannot communicate his/her symptoms indicating a need for a nonprescription medication. (Must contact physician before each dose)

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

Drug	Dosage	Frequency	Reason for Use	Symptoms	Maximum dosage in 24 hr

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_