PRN AUTHORIZATION LETTER

Community Care Licensing - Technical Support Program

Dear Dr._____:

Re: Your patient: _____

   A resident of: _____Homes of Hope Foster Family Agency_____

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 patients 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 _____

Telephone Number_____ Date _____

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 need for prescription and/or nonprcscription PRN medication and cannot communicate his/her symptoms indicating a need for a nonprescription medication.

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

*Physician's Signature*_____ *Date*_____

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