



Shalom Garden, Inc.

Luxury Homes and Care for Seniors

1-877-438-4045

PRN Authorization Letter

To Doctor: _____

Re: Your Patient: _____

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.

Thank you for your assistance.

Sincerely,

Signature: _____ Title: _____

Telephone #: _____ Date: _____

Please check which circumstance describes your patient

- My Patient can determine and clearly communicate his/her need for prescription and non-prescription medication on a PRN Basis.
- My Patient can **NOT** 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 can **NOT** communicate his/her symptoms clearly.

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

	Medication	Strength	Dose	Route	Indication	Dose not to exceed in 24 hours
1						
2						
3						
4						
5						

Physician's Signature: _____ Date: _____