DOCUMENTATION OF PHYSICIAN'S OR OTHER PRESCRIBER’S ORAL ORDER FOR PRN (AS NEEDED) MEDICATION

NAME OF RESIDENT: ________________________________________________________________

NAME OF RESIDENT'S PHYSICIAN OR OTHER PRESCRIBER GIVING ORDER: ________________________________________________________________

DATE OF ORDER: ____________________________

DIAGNOSIS/CONDITION FOR WHICH THE MEDICATION IS PRESCRIBED: _________________________________

MEDICATION PRESCRIBED:

DRUG NAME: ________________________________

STRENGTH: __________________________________

DOSAGE: __________________________________________

ROUTE: __________________________________________

PHYSICIAN'S/OTHER PRESCRIBER'S INSTRUCTIONS:

1. SYMPTOMS THAT INDICATE USE OF THE MEDICATION: ________________________________________________________________

______________________________________________________________

2. TIME FRAMES THE MEDICATION IS TO BE GIVEN IN A 24-HOUR PERIOD: ________________________________________________________________

______________________________________________________________

3. DIRECTIONS IF SYMPTOMS PERSIST: ________________________________________________________________

______________________________________________________________

4. ANY ADDITIONAL INSTRUCTIONS, INCLUDING BUT NOT LIMITED TO, INSTRUCTIONS FOR ADVERSE DRUG REACTION & MEDICATION ERROR:

______________________________________________________________

______________________________________________________________

FACILITY STAFF RECEIVING ORDER:

PRINT: __________________________________________  SIGNATURE: __________________________________________

REVIEW BY PHYSICIAN OR OTHER PRESCRIBER:

PHYSICIAN’S/OTHER PRESCRIBERS SIGNATURE: __________________________________________  DATE ______

032-05-0530-02-eng (02/18)