Medication Clarification/Verification

We have received a medication from our pharmacy (__________________________) which was filled pursuant to a phone order to said pharmacy. In order for our medication assistance providers to administer/supervise self-administration of this medication a written verification that this is a current and correct order is required.

The information provided on that pharmacy label is listed below. Please verify that all of the information is correct. If any information is incorrect please make corrections in the space provided. Please sign and date this form and include your license number in the space provided.

Thank you for your assistance in helping us comply with Fl. Rule 65G-7.

Order as it appears on the Pharmacy Label:

Date Ordered: _____________________________________
Consumer Name: _____________________________________
Drug Name and strength: _____________________________________
Dose and _____________________________________
Directions for Use: _____________________________________
Quantity and # of Refills: ________________________________
Information Needed: _____________________________________
Or Clarification _____________________________________
Signature of Physician: _____________________________________
Date of Signature: ________________________________
Physician’s License #: _____________________________________

Revised 10/14/09
NEW or CHANGED MEDICATION ORDER

Client:____________________________     Date:_____________

Medication Order:  __________________________________________

________________________________________________________________________

☐ Faxed to pharmacy

☐ Medication received IF NOT RECEIVED IN 24H MUST NOTIFY PHARMACY AND MANAGER and MUST DOCUMENT info on reverse of MAR

☐ Order entered on MAR - must match exactly the Prescription as written by physician and the label from pharmacy - if not manager MUST be notified All PRN Meds must include When Physician to be Notified

***If dose change be sure to DC the old order on MAR

☐ Side effects/adverse reaction sheets placed in MAR file

☐ First dose given. Documented on reverse of MAR

☐ Second dose given. Documented on reverse of MAR

☐ Third dose given. Documented on reverse of MAR

☐ Physician notified of any side effects or adverse reaction

10/15/09
PRN MEDICATION INSTRUCTIONS SHEET
(In accordance with the Florida 65G-7 Policy)

Name: ________________________________                       DOB: __________________________

Medication Name:__________________________________Dose:_____________________________
Take_____ Tablet(s)/Capsule(s)by mouth every__________________ for______________________
(No variable interval)                     (indication)
Maximum_______________ in 24 hours
Notify health care provider for:________________________________________________________

Medication Name:__________________________________Dose:_____________________________
Take_____ Tablet(s)/Capsule(s)by mouth every__________________ for______________________
(No variable interval)                     (indication)
Maximum_______________ in 24 hours
Notify health care provider for:________________________________________________________

Medication Name:__________________________________Dose:_____________________________
Apply______ ___________ to __________Every__________________ for______________________
(No variable interval)                     (indication)
Maximum_______________ in 24 hours
Notify health care provider for:________________________________________________________

Coments:_____________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Physician’s Signature:___________________________                       Date:_________________________
PRN/OTC Medication Request

Non licensed staff for Agency for Persons with Disabilities clients must follow this list of requirements before they may administer/supervise medications. Thank you for your assistance.

**65G-7.005 Medication Administration Procedures.** (6) The medication assistance provider may not assist with PRN medications, including OTC medications, unless a health care practitioner has provided written directions for the medication. The provider must attach to the client’s MAR a copy of the prescription or order legibly displaying the following information: (a) The name of the medication; (b) The prescription number, if applicable; (c) The prescribed dosage; and (d) Specific directions for use, including the medical basis for the medication, the time intervals for administration, the maximum number of doses, the maximum number of days that the medication should be administered, and conditions under which the health care practitioner should be notified.

To: ________________________________

From: ______________________________ Date: ___________________

Phone number: ____________________ Fax Number: ______________________

Consumer Name: ____________________

Why Requested/Needed:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Name and strength of medication: ________________________________

Specific dose of medication: ________________________________

Specific reason(s) this medication may be given: ________________________________
____________________________________________________________________________________
____________________________________________________________________________________

May administer/supervise every _____________ hours

Maximum of _____________ doses in a 24 hour period

“If ________________________________ or symptoms persist greater than ________________________________, Call the physician.”

____________________________________________________________________________________

Signature: __________________________ Date: __________________________

Revised 4/10
<table>
<thead>
<tr>
<th>MAR/MEDICATION AUDIT</th>
<th>NAME</th>
<th>NAME</th>
<th>NAME</th>
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</thead>
<tbody>
<tr>
<td><strong>DATE</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Copies of all current prescriptions in file (correlate with MAR, Meds on hand and Healthcare Communication Forms)</td>
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<tr>
<td><strong>MAR reflects current correct medications, correct dose, correct times and correct dates to be given (correlate with prescriptions and Healthcare Communication Forms)</strong></td>
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<tr>
<td>All meds have a start and if appropriate a stop date especially Antibiotics. Check that appropriate dates are marked off when not to be given</td>
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<tr>
<td>All meds not given daily (ex: Fosamax) have appropriate date to be given noted</td>
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<td>All PRN medications state specific parameters upon which a medication is to be given and when physician is to be notified</td>
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<tr>
<td>Documentation of effectiveness of all PRN meds is noted (strongly encouraged)</td>
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<tr>
<td>Diagnosis is noted for each medication on MAR (strongly encouraged)</td>
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<tr>
<td>Allergies noted on MAR</td>
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<tr>
<td>Diet noted on MAR (Strongly encouraged) Must be able to show you the diet listed</td>
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<tr>
<td>Current action, side effects, adverse reactions and interaction information sheets in file for all medications</td>
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<tr>
<td>Reason for missed medications meds is noted along with appropriate physician notification</td>
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<tr>
<td>If medication unavailable from pharmacy documentation of follow up according to Policy and Procedure followed and med obtained</td>
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<tr>
<td>If indicated - Medication error reports are noted with appropriate notification of physician, district, and documentation that correction action has been carried out</td>
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<tr>
<td>Documentation of monitoring client for 20 minutes after first three doses of a new med and after PRN meds</td>
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<tr>
<td>All new orders instituted within 24 hours (Correlate with Healthcare Forms and prescriptions)</td>
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<tr>
<td>Signatures and initials of all persons administering meds or supervising administration of meds are noted</td>
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</tbody>
</table>

**CORRECTIVE ACTION:**

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
Recommendations for use of Mar Audit

1. Monthly at time new MAR is initiated – new MAR reconciled with old MAR with corrections/additions per physician orders. Must be done prior to putting new MAR in the book.
2. When a client has new medication or change in dose, frequency, or med is discontinued.
3. If a medication error occurs.
4. If “holes” are noted.
5. When new employee, who has been trained and validated, begins to administer or supervise the administration of medications. Would recommend auditing the new employee for at least the first week.
6. Written Policy and Procedure for documentation of monitoring MAR should be in place and results of the auditing kept on file along with the corrective actions taken.