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: ___________________________
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