This Form is from an Assisted Living Facility

Assisted Living is a non-medical setting

PRN AUTHORIZATION LETTER

RE: Patient's Name: _____

A Resident of: Lavender Hills Assisted Living Date: _____

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 (box 3, below) ***then you, the physician, must be contacted before the PRN medication can be given each and every time.*** Your completion of this form will serve to document your patient's current ability to determine his/her own need for these medications – and potentially avoid the need to contact you prior to each PRN medication dosing.

Thank you for your assistance.

Sincerely,

Jennifer Boss, Administrator

Please check ONLY ONE BOX that describes your patient's ability.

☐ 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 nonprescription PRN medications, *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 cannot clearly communicate his/her symptoms indicating a need for a nonprescription PRN medication. **(Licensee must contact physician before each dose and at all times.)**

Physician's Signature: _____ Date: _____

Confidential Communication Policy:

The information contained herein is intended only for the recipient and is legally protected private information. If you received this information in error please destroy or return it to Lavender Hills Assisted Living and contact our offices to report the error.

Lavender Hills Assisted Living LLC

License #455002027 #455002615

OVER THE COUNTER MEDICATIONS

Resident: **Physician:**

Please mark a line through any medications(s) you do NOT want given. Instructions and labels will be complied within the maximum dose allowed in a period of time:

Drug Name & Dosage:	Usage:	PRN Dosage:	NOT TO EXCEED:
Acetaminophen 325mg	Fever, headache or minor pain	325mg 1-2 tabs every 4 hours	3,000mg/24 hours
Acetaminophen 500mg	Fever, headache or minor pain	500mg 1-2 tabs every 4-6 hours	3,000mg/24 hours
Aleve 220mg	Pain reliever/fever reducer	220mg capsule 1 every 8-12 hours	3 tabs/24 hours
Ibuprofen 200mg	Pain reliever/fever reducer	200mg 1 tab every 4-6 hours	6 tabs/24 hours
Mucinex 600mg or 1200mg	Congestion/cough	600mg 1-2 tabs every 12 hours 1200mg 1 tab every 12 hours	2400mg/24 hours
Milk of Magnesia 1200mg	Constipation	30ml 2x daily w/ 8oz hot water	120ml/24 hours or 4 doses
Antacid (Generic Mylanta)	Upset Stomach	2tsp by mouth after meals & at bedtime	18tsp/24 hours
Metamucil	Occasional constipation	1 tbs in 8oz of liquid up to 3x	3tbs/24 hours
Pepto Bismol 262mg or 525mg	As directed on the bottle	2 tbs or tab q hour for diarrhea	6 doses/24 hours
Kaopectate 262mg	diarrhea/upset stomach	30ml: may repeat in ½ to 1 hour	8 doses/24 hours
Docusate Sodium	Stool softener/constipation	1-3 soft gels daily	3/24 hours
Senna or Senna S	Constipation	1-3 Tablets daily	8/24hrs
Muscle Rub (Bengay)	Sore muscles	Apply to sore area as needed	4X/daily
Robitussin/Guiatuss (Cough)	Cough Suppressant	2 tsps every 4 hours	6 doses/24 hours
Desitin/Barrier Cream	Minor rash or skin irritation	Apply as often as necessary	No Max listed
Cough Drops	Cough or Sore Throat	1 hour as needed	q hour: 1 week at a time
Vicks Vapor Rub	Congestion	Apply up 3x daily a thick layer w/loose clothing for vapors to reach nose	3x/24 hours
Imodium AD 2mg	Diarrhea	2 tabs after 1st loose stool and 1 tab each thereafter	4tabs/24 hours or 2 days usage
Tums 500mg or 1000mg	Heartburn, upset stomach, or indigestion	1-2 by mouth every hour	10 tabs/24 hours/2 weeks at a time
Benadryl 25mg	Allergies, allergic reactions, sleep aid	1 every 4 hours	6/24 hours
Nyquil	Flu/cold symptoms	2 tbs every 6 hours	4 doses/24 hours: 1 week at a time
Dayquil	Flu/cold symptoms	30ml every 4 hours	4/doses/24 hours
Sudafed	Allergies	30mg 2 tabs every 6 hours	8/24 hours
Ensure/Glucerna	Nutritional Supplement	1 – drink up to 3x daily	3 drinks/24 hours
Generic Eye Drops	Dry, itchy, red eyes	1 drop in each eye up to 4x	4 drops per eye/24 hours
Neosporin/Triple Antibiotic Ointment	Minor cuts & abrasions	Apply up to 3x daily	3x daily: 1 week at a time
Hydrocortisone Cream	For itching/skin irritation	Apply 3-4 times daily	4x daily for 7 days
Miralax 3350mg	Occasional Constipation	17 gm once daily	1 dose per day for 7 days
Alcoholic Beverage	Social Gatherings	1-2 drinks in 24 hours	As requested with dinner or at social gatherings
Postural Support- Bed Rail	As needed on bed for mobility	N/A	N/A

Physician's Signature: _____ Date: _____