Louisiana State Board of Nursing

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http://www.lsbn.state.la.us

MEDICATION REPORT

To the practitioner of the Recovering Nurse Program participant:
Please take a few moments to complete the form below. After completing the form please mail it to the office within five (5) days of prescribing the medication. The completed form must be mailed by the practitioner only. If you have any questions, please call **(225) 755-7546.**

Name of Individual: _____
(Please Print)

Date of Medical Examination: _____
(Date)

Diagnoses: _____

By signature below, I verify that the information below is correct. I have been informed that this individual is a participant in the Recovering Nurse Program and that he/she submits to random drug screens. The use of narcotics or controlled substances should be avoided when alternative treatments are available.

PRESCRIPTION INFORMATION

DATE OF PRESCRIPTION	NAME OF MEDICATION	QUANTITY & DOSAGE NUMBER OF REFILLS	REASON FOR MEDICATION	CONTROLLED, MOOD ALTERING, OR ADDICTIVE	
				YES	NO

_____ Individual's Signature

_____ License # or SSN

_____ Date

_____ Prescriber Signature

_____ Prescriber's Name (Please Print)

_____ Prescriber's Address

_____ Area Code/Phone Number