Louisiana State Board of Nursing

17373 Perkins Road
Baton Rouge, LA 70810
Telephone: (225) 755-7500 Fax: (225) 755-7583
http://www.lsbn.state.la.us

MEDICATION REPORT

To the practitioner:
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. The individual has shared the Board Order/Agreement with the prescribing physician, and has informed the physician of his/her history with the Board of Nursing (Yes__ No__). I understand this individual submits to random drug screens and the use of narcotics or controlled substances when alternative treatments are available should be avoided.

PRESCRIPTION INFORMATION

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

_____ _____
Individual's Signature Prescriber Signature

_____ _____
License # or SSN Prescriber's Name (Please Print)

_____ _____
Date Prescriber's Address

_____
Area Code/Phone Number

(Revised 6/15/2021)