Guidelines for PRN Medication

Resident's Name: ____

Generic Medication Name: ______________ Trade Medication Name: ______________________

What is the medication for? ____

To be given if:____

____

(Specific reason medication is needed, i.e., specific descriptive complaint of pain, behavior, or other symptom)

Not to Exceed: ____

(Number of doses in a specific amount of time, i.e., six tablets in 24 hour period)

Dose of medication:__________________________ Amount to be given:______________________

(i.e. four (4) mg) (i.e. 1 tablet)

How often:_________________________________Route:_____________________________

{i.e. every six (6) hours} (i.e. by mouth, under tongue)

Expected outcome: ____

____

Call Medical Professional or Pharmacist if the following specific adverse reactions or side effects are present:____

____

Medication to be stopped when:_______________________________________

____

Print Authorized First and Last Name: ___________________________________

Authorized Signature: ____________________________Date: __________________

Title of Authorized Signature: ☐ Physician ☐ Nurse Practitioner ☐ PA ☐ RN ☐ Pharmacist

Adult Care Home: ____