Medication Authorization Form for Emergency & Life Saving PRN Medications

Person: _____ Date of Birth: _____

Instructions: This form must be completed by the person's physician. It details the allowable EMERGENCY/LIFE SAVING medications that can be administered while receiving Branches of Life services. Any missing, incomplete, or incorrect documentation will prohibit Branches from administering medication, which can lead to interruption of the person's services.

*** PLEASE FAX THIS COMPLETED FORM AS SOON AS POSSIBLE TO BRANCHES OF LIFE 804-571-6692 ***

For ALL medications, Branches must have each of the following PRIOR to medication administration:

- **THIS FORM MUST BE COMPLETED AND SIGNED BY AN AUTHORIZED PHYSICIAN**
  - **THIS PERSON HAS SIGNED A RELEASE OF INFORMATION FOR THEIR PHYSICIAN. IF NEEDED, REQUEST BY FAXING 804-571-6692**
- **All medications/doses must match what is listed on this form (unless generic is checked, no substitutions are allowed)**
- **This form must remain current for each prescription and must be updated when:**
  - **Any time a Rx has changed from this authorization, it requires a new/updated authorization (for that medication) signed by the physician, as well as a corresponding change to the prescription label.**
  - **Any time a medication from this authorization has been discontinued, it requires signed documentation from the physician and must include the date it was discontinued.**
  - **In order for Branches staff to be able to continue administering medication, this form must be updated PRIOR to the expiration date, which is one year after it was signed by the physician.**

PRESCRIPTION INFORMATION / MEDICATION ORDERS:

Please make sure writing is legible so there is no confusion. Please only list one medication per form.

Medication name: *Ex: Please specify if generic is ok.*	❒ Generic OK ❒ Generic NOT allowed
Medication dose/amount: *Ex: 2 tabs, 500mg, 2 puffs, etc*	
Reason for taking medication: *Ex: allergic reaction, seizure lasting 5 mins, etc*	
Protocol for when to administer: *Ex: When ____ happens, administer ____.* *Please be as specific as possible.*	
Is this medication:	❒ New ❒ Continued ❒ Discontinued ❒ Updated (please explain what changes are being made)
Is this a psychotropic medication?	❒ Yes ❒ No

***If "yes" has been checked above, the physician listed below has prescribed a drug to the individual listed above, that is considered a psychotropic medication. A Psychotropic medication is any medication capable of affecting the mind, emotions, and behavior. The individual listed above may be taking this medication when they are receiving Branches of Life Services. It is important that the individual give informed consent for the use of the currently prescribed psychotropic medications. By signing below, the physician has informed the individual of the effects of psychotropic medication, and the individual has given consent for the medication to be administered.**

Physician's Name: _____ Phone Number: _____

Physician's Signature: _____ Date: _____

*** * THIS FORM EXPIRES ONE YEAR FROM THE ABOVE DATE * ***