

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: \_\_\_\_\_