

OKLAHOMA BOARD OF NURSING
2915 N. Classen Blvd., Suite 524
Oklahoma City, OK 73106

Telephone: 405/962-1800
Facsimile: 405/962-1819
Website: www.ok.gov/nursing

MEDICATION REPORT

Please take a few moments to complete the form below. **After completing the form, please mail it directly to the Program office. The completed form must be mailed by the practitioner only.** If you have any questions, please call the Oklahoma Board of Nursing.

NURSE NAME: _____
Print Name

PRESCRIPTION INFORMATION (please print)

Date of RX	Name of Medication	Dosage	Amount Prescribed	Number of Refills	Reason Prescribed

I have been informed this patient is being monitored for drug-related issues. I am aware that the continued use of mood altering substances increases the risk of drug dependency.

Practitioner Name (Please Print)

Practitioner Signature

Practitioner Office Phone Number

Date

I, _____ hereby authorize _____
to disclose to the Oklahoma Board of Nursing, including staff and Oklahoma Board of Nursing Board members, any and all information relating to medical treatment which may be requested.

(Nurse's signature/date)

(Witness' signature/date)

Revised: 09/06/07; 10/20/08