Medication Reason for Use

Date:__________________________

Consumer:____

DOB:____

Dear Doctor:____

Your Patient,______________________________________ , is a resident of_________________ ____.In order for us to ensure an accurate understanding of medications prescribed as they relate to health and safety, we are requesting documentation from you stating the reason why our resident is being prescribed medication. Each medication prescribed to the above-mentioned consumer is listed below; please complete the "reason for use" section.

Drug	Dose	Frequency Given	Reason for Use (Physician to fill out this section)

____
Physician's Signature

____
Date Signed

(Please affix physician's stamp with license number below)