Bedtime Medication Authorization Form

Name_____ Date_____

Date of Birth_____

Home_____

Print Doctor/Nurse Practitioner's Name_____

Physician/Nurse Practitioner's Phone Number_____

Bedtime Medications for the Client_____

_____

_____

_____

_____

I give permission for this client to receive their bedtime medications between the hours of 8:00pm and 11:59pm.

_____

Physician/ NP Signature

Please fax this signed form back to _____ at _____.

If you have any questions, please contact the Program Manager_____

at _____.

*Send a copy of this form to the pharmacy. If bedtime meds change, a new form needs to be signed and sent to the pharmacy. This form needs updated annually.