PINNACLE
ASSISTED LIVING SERVICES

MEDICATION AUTHORIZATION

Resident Name: _____ Birth Date: _____

Address:

_____

_____

Medicaid Waiver Standards for Wisconsin under SPC 202.01 state:

"For the sponsor to administer or assist a resident in administering any prescription medication there shall be a written order from the physician who prescribed the medication. The written order shall specify under what conditions and what dosage medication may be administered."

I authorize the AFH/CBRF Provider and all trained staff to administer schedule medication including over the counter medications. Medications are to be administered per directions on the pharmacy label. Please list all medications the resident needs assistance in taking: (Computer print of scheduled medications may be attached.)

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_____
_____
_____
_____
_____
_____
_____

All "As Needed" prescription medication requires a statement which defines under what conditions the "as needed" medication can be given.

_____
_____
_____
_____

Physician signature **Date**