Medication Report

IPN Case # _____Participants Name: _____

THIS FORM TO BE USED ONLY WHEN TAKING SHORT TERM PRESCRIBED MEDICATION.

To the Practitioner of _____, a participant in the Intervention Project for Nurses (IPN): Please take a few moments to complete the form below. After completing the form, please fax 904-270-1633 or mail to:

Intervention Project for Nurses
P.O. Box 49130
Jacksonville Beach, FL 32240-9130

PLEASE DUPLICATE THIS FORM PRIOR TO USE, FOR FUTURE USE.
If you have any questions, please call IPN at (1-800) 840-2720.

PRESCRIPTION INFORMATION					
Date of Rx	Name of Medication	Dosage	Qty. Prescribed	# of Refills	Reason for Medication

I have been informed this patient is a participant in IPN? YES____ NO____

Practitioner's Name (Please Print): _____

Practitioner's Signature_____

Address: _____

City_____State_____Zip_____

Phone: _____ Date:

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