STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

CENTRALLY STORED MEDICATION AND DESTRUCTION RECORD

I. CENTRALLY STORED MEDICATION

FACILITY NAME

FACILITY NUMBER

INSTRUCTIONS: *Centrally stored medications shall be kept in a safe and locked place that is not accessible to any person(s) except authorized individuals. Medication records on each client/resident shall be maintained for at least one year.*

NAME (LAST FIRST MIDDLE)	ADMISSION DATE	ATTENDING PHYSICIAN	ADMINISTRATOR

MEDICATION NAME	STRENGTH/ QUANTITY	INSTRUCTIONS CONTROL/CUSTODY	EXPIRATION DATE	DATE FILLED	DATE STARTED	PRESCRIBING PHYSICIAN	PRESCRIPTION NUMBER	NO. OF REFILLS	NAME OF PHARMACY

MEDICATION NAME	STRENGTH/ QUANTITY	INSTRUCTIONS CONTROL/CUSTODY	EXPIRATION DATE	DATE FILLED	DATE STARTED	PRESCRIBING PHYSICIAN	PRESCRIPTION NUMBER	NO. OF REFILLS	NAME OF PHARMACY

II. MEDICATION DESTRUCTION RECORD

INSTRUCTIONS: *Prescription drugs not taken with the client/resident upon termination of services or otherwise disposed of shall be destroyed in the facility by the Administrator or Designated Representative and witnessed by one other adult who is not a client/resident. All facilities except Residential Care Facilities for the Elderly (RCFEs) shall retain destruction records for at least one year. RCFEs shall retain records for at least three years.*

MEDICATION NAME	STRENGTH/ QUANTITY	DATE FILLED	PRESCRIPTION NUMBER	DISPOSAL DATE	NAME OF PHARMACY	SIGNATURE OF ADMINISTRATOR OR DESIGNATED REPRESENTATIVE	SIGNATURE OF WITNESS ADULT NON-CLIENT

CLIENT: FACILITY : MONTH/YE AR:

DAILY MEDICATION LOG

HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Medication:
NAME :
STRENGTH :
DOSAGE :
PURPOSE:
MAJOR SIDE EFFECTS:

Medication:
NAME :
STRENGTH :
DOSAGE :
PURPOSE:
MAJOR SIDE EFFECTS:

Medication:
NAME :
STRENGTH :
DOSAGE :
PURPOSE:
MAJOR SIDE EFFECTS:

Medication:
NAME :
STRENGTH :
DOSAGE :
PURPOSE:
MAJOR SIDE EFFECTS:

COMMENTS
ALLERGIES :
SIGNATURE / INITIAL:

LEGEND : D/C = DISCONTINUED D/P = DAY PROGRAM R = REFUSED H = HOME 0 = DATE STARTED

PRN Medication Log

Date	Time	Medication	Dosage	Reason	Time Dr. called	Results	Initials/Name

Name of Client_____Allergies_____

Name of Physician_____

PRN AUTHORIZATION LETTER

Community Care Licensing - Technical Support Program

Dear Dr. _____:

Re: Your patient: _____

A resident of: _____

To receive nonprescription and prescription PRN medications, state licensing requires that either:

1) your patient be capable of determining his/her own need for the medication, **or**
2) for nonprescription medication only, be able to clearly communicate his/her symptoms.

If your patient cannot determine his/her need for a medication, or, clearly communicate the symptoms for a nonprescription medication then you, the physician, must be contacted before the PRN medication can be given. Your completion of this form will serve to document your patient's current ability to determine his/her own need for these medications.

As a licensed care provider, it is my responsibility to monitor your patient's continued ability to determine his/her own need for PRN medications and inform you of any changes which indicate he/she can no longer make these decisions.

Thank you for your assistance.

Sincerely,

Signature _____ *Title* _____

Telephone Number _____ *Date* _____

Please check which circumstance describes your patient:

___ My patient can determine and clearly communicate his/her need for prescription and nonprescription medication on a PRN basis.

___ My patient cannot determine his/her own need for nonprescription PRN medication, but can clearly communicate his/her symptoms indicating a need for a nonprescription medication.

___ My patient cannot determine his/her need for prescription and/or nonprescription PRN medication and cannot clearly communicate his/her symptoms indicating a need for a nonprescription PRN medication. (Licensee must contact physician before each dose.)

The following prescription and nonprescription medications can be taken by this patient on a PRN basis:

_____ _____ _____

_____ _____ _____

Physician's Signature _____ *Date* _____