

Physician Authorization

Dear Dr. _____ Date _____

Regarding your patient: _____

Your authorization below will serve to document your patient's current cognitive ability to self-administer prescription and nonprescription medications (on a routine or PRN basis) AND to maintain and use specific household chemicals.

Medication Name: _____ **FULL ORDER:** Dosage/Route/Frequency _____

Medication Name:	FULL ORDER: Dosage/Route/Frequency

Household chemicals:

➔ This patient IS IS NOT cognitively able to safely store and self-administer the above medications.

➔ This patient IS IS NOT cognitively able to safely store and use the above household chemicals.

➔ **Physician's Signature** _____ **Date** _____

YOU MAY RETURN THIS FORM ALONG WITH THE PHYSICIAN'S REPORT, OR FAX TO US. THANK YOU FOR TIME AND ATTENTION.



MARKETING DEPARTMENT
2705 MOUNTAIN VIEW DRIVE
LA VERNE, CA 91750
(909) 392-4111 FAX (909) 392-4036
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