HOPE HAVEN

3815 N. Tryon Street
Charlotte, NC 28206
704-372-8809
1-833-328-5728 Admissions Fax

North Carolina Dept. of Health & Human Services requires that we have a note from the physician stating the patient may self-administer all **prescribed and OTC** medications. Please complete this form and give it to your patient to return to us. NC State Statute says that only those persons with the following credentials: M.D., P.A. or N.P. can legally write prescriptions, and therefore may sign this form.

Client Name _____

MEDICINE	**DOSAGE**	**REASON PRESCRIBED**
☐ **No medications prescribed during this visit**		

*******The information on this document certifies that this person may self-administer these medications. For children under age 18, this document certifies that the parent/guardian may administer these medications to the child.

Informed Consent

I give authorization for the above named medications to be released to Hope Haven. I understand that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is truly voluntary. I further acknowledge that I may revoke this consent at any time except to the extent action base on the consent has been taken.

Client Signature & Date: _____

Prescriber Signature & Date: _____

Medical Facility_____

Thank you for your help in better serving our residents,

President, CEO