

LOUISIANA STATE BOARD OF PRACTICAL NURSE EXAMINERS
3421 NORTH CAUSEWAY BOULEVARD, SUITE 505
METAIRIE, LOUISIANA 70002-3715
(504) 838-5791
FAX (504) 838-5279
www.lsbpne.com

CONTROLLED MEDICATION(S)/ABUSE POTENTIAL SUBSTANCE(S) FORM

(This form is to be completed by the licensed practitioner from whom you obtain any prescription for controlled medication(s), it must come directly from the practitioner and will not be accepted in any other form and may not be submitted by facsimile).

THE FOLLOWING MUST BE SUBMITTED WITHIN 5 DAYS OF RECEIPT

1. That you have been informed by _____ **LPN** that this patient has provided you with information that he is under a probated contract with the Louisiana State Board of Practical Nurse Examiners, to provide this information to the Board.

a. **Diagnosis:**

b. **Type of medication(s) prescribed:**

c. **Dosage of medication(s) and amount dispensed:**

d. **Date the medication(s) prescribed:**

e. Last date this patient was prescribed the above medication(s)?

f. Will this patient be prescribed the above medication(s) on a regular basis?

If yes, please state reason(s):

PRINT NAME HERE (Prescribing Licensed Practitioner)

Telephone number

SIGNATURE (Prescribing Licensed Practitioner)

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THIS SECTION IS TO BE USED IF MEDICATIONS ARE TO BE REFILLED:

2. Please indicate the need for the above to continue said medication(s)

- a. Date authorized:
- b. Medication and amount dispensed:
- c. Dosage:

The board thanks you in advance for your cooperation in this matter.

Bridget Lassere
Compliance Department