GREYSTOKE HOME HEALTH

Medication Authorization

CBI HEALTH GROUP

CONSENT FOR MEDICATION ASSISTANCE

PLEASE READ INFORMATION AND PROCEDURES

I hereby request CBI Greystoke Home Health (CBIGHH) administer medication as directed by this authorization. I am aware that staff providing this assistance is non-professional unregulated staff. I agree to hold harmless CBIGHH and any of their staff or agents for helping this person served use medication, provided caregivers comply with physician or guardian directives. I have read and been informed about the content, requirements and procedures outlined on this form and in CBIGHH Medication Policy and assume responsibility as required.

Person Served / Guardian to complete

NAME OF PERSON SERVED / GUARDIAN

I understand that as per CBIGHH Medication Policy, medication training is completed by a regulated CBIGHH RN/LPN for all staff expected to assist with or administer medication. When it is necessary, and in compliance with policy, CBIGHH caregivers are permitted to administer medications under the direction of his/her CBIGHH Supervisor. Assistance shall be with regularly scheduled medications, over-the-counter and PRN medications in specific situations with clear directions for the caregiver. Caregivers must first meet training requirements of an assigned/delegated task specific to individual care. As per policy, medications may only be administered with prior written consent from the appropriate person served/guardian. Injectable medications are not administered except in specific emergency/crisis situations and only under the direct or indirect supervision of a regulated nurse or related health professional.

_____ _____

PERSON SERVED / GUARDIAN SIGNATURE **DATE**

PRESCRIPTION NAME(S) as on bottle, blister pack, strip, or dosette (i.e., antibiotic, antiviral, etc.).

Medication (Drug Name)	Route	Amount/Dosage	Frequency/Admin times

OVER-THE-COUNTER / PRN MEDICATIONS (for relief of symptoms of headache, pain, cold and flu, etc.) PRN prescribed medication must be appropriately packaged; over the counter medication must be in the original container with the name of the medication visible. If medication is given on an as needed basis, specify the symptoms or conditions when medication is to be taken, the amount to be taken, and the time at which it may be given again.

Medication (Drug Name)	Diagnosis/Purpose	Dosage	Frequency/Admin times

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I authorize CBI Greystoke Home Health (CBIGHH) to receive/access any information regarding the medications listed above from my pharmacist and/or physician. Their contact information is as follows:

_____
Name / Phone Number

_____
Name / Phone Number

_____
Name / Phone Number

I understand this consent will be in effect for one (1) year and that I have the right to withdraw my consent at any time and that CBIGHH has the right to withdraw medication assistance at any time. Medication assistance may be adjusted based upon persons served needs.

If any medications listed above change (i.e., dosage, time taken, etc.), I understand that it is my responsibility to inform CBIGHH at the time this change occurs (sooner where known in advance).

_____ _____
Person Served/Guardian Name and Signature Date

_____ _____
Greystoke Representative Name and Signature Date