

## PRESCRIPTION IDENTIFICATION FORM

The nurse identified below is involved in an on-going urine drug screening program.

Please submit this original form to the Missouri State Board of Nursing within five (5) days to ensure accurate documentation for those screens. The mailing address is:

Missouri State Board of Nursing  
PO Box 656  
Jefferson City, MO 65102

If you have any questions, please call (573) 751-6541.

Name of Nurse/Patient: \_\_\_\_\_

License Number: \_\_\_\_\_

I have been informed that this patient has had an allegation of or is chemically dependant. I understand that the alleged drug(s) of choice and/or abuse has been:

- 1.
- 2.
- 3.
- 4.

Prescription Date	Name of Medication	Quantity and Dosage Prescribed/Number of Refills	Reason for Medication

It is recommended that a licensee receive no more than a one month supply of any controlled medication in a single prescription. A Prescription Identification Form must be completed with each refill.

Your signature represents that you have discussed alternatives with the licensee and that in your opinion there is no effective alternative.

\_\_\_\_\_  
Physician's Name (Please Print)

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Physician's Office Phone Number

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Address

**ORIGINAL TO BE RETURNED BY PRESCRIBING PHYSICIAN**