Louisiana Board of Social Work Examiners

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Baton Rouge, LA 70809
Telephone: (225) 756-3470 Fax: (225) 756-3472
http://www.labswe.org

MEDICATION REPORT

To the practitioner:
Please take a few moments to complete the form below. After completing the form please mail the **original** it to the office within five (5) days of prescribing the medication. The completed form must be mailed by the practitioner only. If you have any questions, please call (225)756-3470.

Name of Individual: _____
(Please Print)

Date of Medical Examination: _____
(Date)

Diagnoses: _____

By signature below, I verify that the information below is correct. The individual has shared the Board Order/Agreement with the prescribing physician, and has informed the physician of his/her history with the Louisiana Board of Social Work Examiners (Yes__ No__). I understand this individual submits to random drug screens and the use of narcotics or controlled substances when alternative treatments are available should be avoided.

PRESCRIPTION INFORMATION

DATE OF PRESCRIPTION	NAME OF MEDICATION	QUANTITY & DOSAGE # OF REFILLS	REASON FOR MEDICATION	CONTROLLED, MOOD ALTERING, OR ADDICTIVE	
				YES	NO

_____
Individual's Signature

_____
License # or SSN

_____
Date

_____
Prescriber Signature

_____
Prescriber's Name (Please Print)

_____
Prescriber's Address

_____
Area Code/Phone Number