
Advanced Practice Registered Nurse Prescriptive Agreement

This prescriptive agreement must be filled out, signed and kept at the Advanced Practice Registered Nurses (APRN) place of employment per Chapter 148.235, Subdivision 4, 1999 Minnesota Session Laws "Standards for Written Agreements: Reviewing and Filing." This agreement need not be filed with the Minnesota Board of Nursing or the Minnesota Board of Medical Practice.

* 1. Physician and APRN credentials

APRN

* Name: _____

* Degrees / Certification (s) / Specialty: _____

Experience: _____

Physician

* Name: _____

* Degrees / Certification (s) / Specialty: _____

Experience: _____

* 2. Description of Patient Population to be seen by APRN

Check the boxes that describe the appropriate settings:

Clinic

Surgical Center

Long Term Care

Hospital

Homecare

Other (specify) _____

Patient characteristic(s):

Ages: Child

Adolescent

Adult

Elderly

Types of conditions:

All

Specify: _____

Physician availability for consultation and/or joint management and/or referral:

Expectation(s) of either party regarding communications related to patients:

* 3. Prescriptive Authority

In this section, indicate the categories of drugs and/or devices which may be prescribed by the APRN including any limitations to these categories. Check the box that applies to your practice.

All drug categories or therapeutic devices may be prescribed as listed in the following formulary or reference: _____ (list reference here)

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With the following exceptions: _____

Prescriptive authority extends to the following list of drug categories:

Please make a complete list, or attach a list of drug categories to this agreement.

(NOTE: when making a list of drug categories on your own, be sure to make the list complete using a list that is accepted and known in your practice. It is important to not inadvertently exclude a category with a drug in it that you will be prescribing. If you do attempt to make your own list and there are omissions, the prescriptions that you write in this omitted category will not be legal.)

* 4. Termination or suspension of this agreement (this section must describe how the continuity of care for patients will be assured if the agreement is terminated.) _____

*5. Renewal Requirement(s)

This agreement shall be officially reviewed, renewed and signed at a minimum of annually from the date of signature. We the undersigned agree to review this document on _____. By our signatures we agree to follow the parameters specified above. Furthermore, by signing, the APRN agrees to refer all client's to the physician for a face to face contact at some time during the client's course of treatment, and the physician agrees to accept those referrals _____. (insert date)

APRN

* Name: _____

* Address: _____

* Phone: _____

* Signature: _____

* Date: _____

Physician

* Name: _____

* Address: _____

* Phone: _____

* Signature: _____

* Date: _____



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