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)

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

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.

APRN
* Name: _____

* Address: _____ * Phone: _____

* Signature: _____ * Date: _____

Physician
* Name: _____

* Address: _____ * Phone: _____

* Signature: _____ * Date: _____

Minnesota Nurses Association
1625 Energy Park Drive, Suite 200
St. Paul, MN 55108
Phone: (651) 646-4807
Fax: (651) 647-5301
Web: www.mnnurses.org
E-Mail: mnnurses@mnnurses.org

Minnesota Medical Association
1300 Godward Street NE, Suite 2500
Minneapolis, MN 55413
Phone: (612) 378-1875
Fax: (612) 378-3875
Web: www.mmaonline.net
E-Mail: mma@mnmed.org

List of Drug Categories:

- ☐ Anti-infectives
- ☐ Autonomic and central nervous system medications
- ☐ Dermatological medications
- ☐ Ear-nose-throat medications
- ☐ Endocrine medications
- ☐ Gastrointestinal medications
- ☐ Immunological and vaccines
- ☐ Musculoskeletal medications
- ☐ Nutritional products
- ☐ Obstetrical and gynecological medications
- ☐ Ophthalmic medications
- ☐ Respiratory medications
- ☐ Urological medications
- ☐ Diagnostic and miscellaneous medications

In addition, the following therapeutic devices may be prescribed:

_____

_____

_____

_____

_____

_____