

NURSE'S 72-HOUR MEDICATION REPORT

NURSE NAME: _____
 (Print Name)

To be completed by the nurse within 72 Hours whenever the nurse receives a new prescription medication, over-the-counter medication, and/or recommendation for any marijuana product(s). If you have any questions, please call the Oklahoma Board of Nursing at (405) 962-1827.

PRESCRIPTION AND/OR OVER-THE-COUNTER ("OTC") MEDICATION(S)

(Please print and complete all boxes as appropriate.)

Date Prescribed and/or OTC Taken	Name of Medication	Dosage	Frequency	Number Prescribed	Detailed Purpose	Name of Prescribing Healthcare Provider ("Prescriber")
<i>Example:</i> 7/1/2023	Levothyroxine	.025 mg 1 tab	Daily	30 tabs	Thyroid disease	John Doe, M.D.
<i>Example:</i> 7/1/2023	Tylenol PM	500mg/ 25mg 1 tab	Bedtime 3 times per week	OTC	sleep	OTC
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						

I declare and affirm that the information documented on this form is true, complete and correct. I understand that any false or misleading information shall be cause for the nurse's appearance before the Board.

 (Nurse signature)

 Date

Please complete in the designated online compliance system, mail, scan, or fax (405) 962-1819 to the Board office. Please be advised that a verbal report will NOT be accepted.

Please refer to the Board's Body Fluid Testing Guidelines when completing the Nurse's 72-Hour Medication Report.