# PATIENT/RESIDENT LEAVE OF ABSENCE (LOA) MEDICATION REQUEST FORM

Addressograph/Place Label Here

_____
Authorizing Prescriber

Patient/Resident Leaving on _____ / _____ , 20__, _____
*Day* *Month* *Time*

Patient/Resident Returning on _____ / _____, 20___, _____
*Day* *Month* *Time*

Compliance Package: ☐ Yes ☐ No
If yes, provide reason: _____

☐ Medication Administration Record (MAR) attached

**All scheduled medications will be filled by Pharmacy. Fax Medication Administration Record and completed LOA form to Pharmacy. Original to remain in chart.**

| Regularly Used PRN Medications | Usual Dose (e.g. 2 Tabs) | Number of Doses Required |
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_____ _____
Nursing Date Faxed (dd/mm/yyyy)

_____ _____ _____
Filled By Pharmacist Date Filled (dd/mm/yyyy)