Mississippi Board of Nursing, Compliance Division
Prescription Information Letter

Dear Healthcare Provider:

The nurse who is submitting this form is enrolled in the Compliance Program with the Mississippi Board of Nursing. The Compliance Program monitors nurses with substance use disorders. In order to retain his/her license, the nurse has been placed under an order by the Board to participate in the Compliance Program to ensure abstinence and the ability to practice safely. All prescribed mind–mood altering and potentially addictive medications must be reported to the Compliance Program, by the prescriber using the provided form, immediately and at least every 3 months.

Compliance identifies mind-mood altering or potentially addictive medications as:

- All medications on the U.S. DEA schedule.
- Some medications not listed on the U.S. DEA schedule such as Atropine, Benadryl, Dextromethorphan and all alcohol containing preparations.
- Mental health medications such as antidepressants and antianxiety medications.

Nurses in the Compliance program possess a higher risk of relapse from both prescription and some over-the-counter medications. Therefore, Compliance also requires a health care provider's recommendation for the use of mind-mood altering and potentially addictive over-the-counter medications such as antihistamines, antitussive/expectorants, and weight loss medications.
Alternatives to the use of mind-mood altering and potentially addictive medications should always be considered. A good resource for persons in recovery is the Talbott Medication Guide
http://www.talbottcampus.com/index.php/medication-guide/

Compliance cannot provide treatment recommendations; however, we may require the nurse to receive additional consultation from a mental health, addictions, and/or pain management specialist. Please contact Compliance at any time with questions, comments, or concerns regarding prescription medication procedures including requirements for third party consultation.
Compliance requests that you:

1. Review the nurse's Mississippi Prescription Monitoring Program (PMP) report before you prescribe any new or existing medications and FAX/email a copy along with the Prescription Information Form.
2. Adhere to the opioid prescribing practices contained in the Interagency Guideline on Prescribing Opioids for Pain.

_____ _____
Health Practitioner Signature Date

_____ _____
Agency/Practice Telephone/Fax

_____
Name of Patient

Please sign, fax or email the Prescription Monitoring Program report and the Prescription Information Form to the Compliance Division fax (601) 957-6301, or email to vrucker@msbn.ms.gov, nduncan@msbn.ms.gov or rhance@msbn.ms.gov .

Created10/12/2017
Modified 8/15/2019

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This form is to be completed by the healthcare provider for all prescribed mind-mood altering and potentially addictive medications every 3 months. Please sign and fax (601) 957-6301 or email vrucker@msbn.ms.gov, or cblackwell@msbn.ms.gov the completed form to the Compliance Division.

Patient Name (print name)

_____

Date Prescribed	Name of Medication	Dosage	Frequency	Quantity	Expiration Date	Diagnosis/Reason for Medication

Healthcare Provider Report:

Appointment frequency: _____ Date of next appointment:_____
Y__ N__ I have been informed this nurse is in recovery for substance abuse disorder?
Y __ N__ Is the nurse compliant with keeping appointments?
Y __ N__ Is the nurse compliant with taking medications?
Y __ N__ Does the nurse demonstrate insight, awareness, and judgement necessary to manage medication(s)?
Y __ N__ Is a copy of the nurse's Prescription Monitoring Program report attached?
Y __ N__ Based on the above information and provider's clinical judgement, is the nurse safe to practice at this time?
Y __ N__ Copies of ALL prescription attached?

(If you answer "no" to any of the questions above, please explain below)

Treatment Progress Report:

_____

_____

Healthcare Provider Information: (Please print)

Name: _____Credentials:_____

Facility/Name of Practice: _____

Address: _____City:_____ State:_____ Zip Code _____

Phone: _____ Fax _____

Signature: _____ Date:_____