

Mississippi Nurse Voluntary Program (MnVP)

Medication Verification Form

Dear Healthcare Provider:

The nurse who is submitting this form is enrolled in the Mississippi Nurse Voluntary Program (MnVP) at the Mississippi Board of Nursing. MnVP monitors nurses with substance use and/or mental/behavioral health issues. In order to retain his/her license, the nurse has signed an agreement to participate in MVP to ensure abstinence and the ability to practice safely. All prescribed medications must be reported to the MnVP staff, by the prescriber using the form provided, immediately and at least every three (3) months.

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

MnVP 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 MVP at any time with questions, comments, or concerns regarding prescription medication procedures including requirements for third party consultation. Thank you for assistance.

MnVP requests that you:

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

Healthcare Provider Signature

Date

Agency/Practice

Telephone/Fax

Patient's Name

Please sign, fax/email the Prescription Monitoring Program report and the Medication Verification Form to MVP: fax - 601.957.6301 (attn: MnVP) or MNVP@msbn.ms.gov

Medication Verification Form

This form is to be completed by the Healthcare Provider for all prescribed medications every three (3) months. Please sign and fax (601.957.6301 attn: MnVP) or email (MNVP@msbn.ms.gov) the completed form.

Patient's Name (printed): _____

Name of Rx	Dosage	Frequency	Quantity	Expiration	Dx/Reason for
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Healthcare Provider Report:

Appointment Frequency: _____ Date of Next Appointment: _____

1. I have been informed this nurse is in recovery for substance abuse. Y__ N__
2. Is the nurse compliant with keeping appointments? Y__ N__
3. Is the nurse compliant with taking medication? Y__ N__
4. Does the nurse demonstrate insight, awareness and judgement necessary to manage medication(s): Y__ N__
5. Is a copy of the nurse's Prescription Monitoring Program report attached? Y__ N__
6. Based on the above information and provider's clinical judgement, is the nurse safe to practice at this time? Y__ N__

If you answer "no" to any of the questions above, please explain:

Treatment Progress Report:

Healthcare Provider Information:

Name: _____ Credentials: _____

Facility/Name of Practice: _____

Address: _____

Phone: _____ Fax: _____

Provider's Signature: _____ Date: _____

**Mississippi Nurse
Voluntary Program (MnVP)**

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