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: ___________________________
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: