State of Louisiana
Department of Health and Hospitals
Louisiana Physical Therapy Board
2110 W. Pinhook Road Ste. 202 | Lafayette, Louisiana 70508
Phone 337-262-1043 | Fax 337-262-1054 www.laptboard.org |
info@laptboard.org

MEDICATION REPORT

To the practitioner:
Please take a few moments to complete the form below. After completing the form please mail it to the office within THREE (3) days of prescribing the medication. The completed form must be faxed or mailed by the practitioner only. If you have any questions, please call (337) 262-1043.

Name of Individual: _____

Date of Medical Examination: _____

Diagnoses: _____

By signature below, I verify that the information below is correct. The individual has shared the Board Order/Agreement with the prescribing physician, and has informed the physician of his/her history with the LPTB (Yes__ No__). I understand this individual submits to random drug screens and the use of narcotics or controlled substances should be avoided when alternative treatments are available.

PRESCRIPTION INFORMATION

DATE OF PRESCRIPTION	NAME OF MEDICATION	QUANTITY & DOSAGE # OF REFILLS	REASON FOR MEDICATION	CONTROLLED, MOOD ALTERING, OR ADDICTIVE YES/NO

Individual's Signature _____

Date _____

Prescriber Signature _____

Prescriber's Name (Please Print) _____

Prescriber's Address / Phone # _____