Date:

To: Dr.
GP Practice:

Request for G.P Authority - Medications

Client First name:
Client Surname:
D.O.B:
Address:

Dear Dr

We are requesting that Empower Healthcare - Home Nursing visit your client detailed above for administration of medications.

To undertake the service, they will require an appropriate signed authority.

Could you please provide this including the dose, route, and timing for each of the medications.

Alternatively complete and sign the form below and return directly to me.

Kind Regards,

Medical Authority to Administer Medicines

Client Details:					
First Name				Last Name	
Date of Birth	DD	MM	YYYY	Gender	☐ M ☐ F

Medicine Generic name where possible	Dose	Strength	Frequency	Route

Doctor's Name	
Phone	
Provider Number	
Signature	sign here
Date	