Prescription adaptation notification

Date ______________________

Should you wish to discuss the care of our mutual patient further, please feel free to contact me.

From

Pharmacist name:

Practice permit #:

Pharmacy name:

Address:

Phone: Fax:

To

Prescriber:

Fax:

Regarding

Patient:

Address:

AHC #: DOB:

Pharmacist's assessment and rationale

Information I gathered (subjective/objective) and my rationale for the adaptation:

References I checked *(if applicable)*:

Adapted therapy assessed to be:

☐ indicated ☐ effective ☐ safe
☐ Patient is willing to adhere to therapy

Follow-up and monitoring plan discussed with patient:

I have adapted this patient's prescription in the following way:

☐ Dosage change ☐ Formulation change
☐ Regimen change ☐ Therapeutic substitution
☐ Renewal for continuity of care

For renewal, attach original prescription label here or indicate the original Rx # below

Original Rx #:

The following adapted prescription was dispensed:

Date:

Drug and strength:

Directions:

Quantity:

Pharmacist signature: ______________________

This facsimile contains confidential information intended only for the prescriber named above. If you are not the prescriber or the prescriber's agent, do not disseminate, distribute, or copy this communication. If you received this communication in error, we apologize for the inconvenience and ask that you notify the sender and delete the material.