PHARMACIST - PRESCRIBER COMMUNICATION

Date: __________________________          Patient Name: __________________________

To (Prescriber): __________________________          Patient PHN: __________________________

Fax: __________________________          Prescription Form Folio Number: __________________________

From (Pharmacy): __________________________          Pharmacy Fax: __________________________

Pharmacist: __________________________          Pharmacy Telephone: __________________________

For Prescriber’s Information and Patient Records

☐ This patient missed their methadone dose __________________________ (dates).

☐ This patient did not take their full daily dose today __________________________ (date) and consumed only _____ mg of the _____ mg prescribed dose.

For Prescriber’s Signature and Return of Form to Pharmacy

☐ We require clarity regarding the ‘prescribing date’ and/or ‘start day’ for the attached Methadone Maintenance Controlled Prescription form. Please indicate the actual ‘prescribing date’ (actual date the prescription was written) and dispensing ‘start date’ or range.

Prescribing Date: __________________________
Dispensing Start Date or Range: __________________________

☐ We require clarification and/or a change to the ‘Directions for Use’ section of the attached Methadone Maintenance Controlled Prescription form.

Description of authorized changes:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Prescriber’s Name: __________________________

CPSID: __________________________

Prescriber’s Signature: __________________________

Signature Date: __________________________

Affix Methadone Maintenance Controlled Prescription form here