

**Pharmacist Prescription Adaptation  
DOCUMENTATION AND NOTIFICATION FORM**

**PATIENT INFORMATION**

Name: \_\_\_\_\_  
PHN: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Name: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

**ORIGINAL PRESCRIPTION INFORMATION**

Date of Prescription: \_\_\_\_\_  
Prescription Details: \_\_\_\_\_  
\_\_\_\_\_

**PHARMACIST INFORMATION**

Name: \_\_\_\_\_  
Pharmacy: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_  
Signature: \_\_\_\_\_

**ADAPTATION INFORMATION**

Date of Adaptation: \_\_\_\_\_  
Adaptation Details: \_\_\_\_\_  
\_\_\_\_\_

**RATIONALE FOR ADAPTATION (INCLUDING INSTRUCTIONS TO PATIENT AND FOLLOW-UP PLAN)**

**Rationale**

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

**Instructions to Patient**

\_\_\_\_\_

\_\_\_\_\_

**Follow-up Plan**

\_\_\_\_\_

\_\_\_\_\_

**INFORMED CONSENT**

The patient and/or their representative (name: \_\_\_\_\_) was provided sufficient information, including the risks and benefits associated with the adaptation and voluntarily provided their consent.

**NOTIFICATION INFORMATION**

Date of Notification: \_\_\_\_\_ Name of Practitioner(s) Notified: \_\_\_\_\_  
Method of Notification (fax preferred): \_\_\_\_\_  
 Fax # \_\_\_\_\_  Phone # \_\_\_\_\_  Other \_\_\_\_\_

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