

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 Controlled Prescription Program 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 Controlled Prescription Program form.

Description of authorized changes: _____

Prescriber's Name: _____

CPSID: _____

Prescriber's Signature: _____

Signature Date: _____

Affix Controlled Prescription Program form here