

**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

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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