Appendix 6

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 __________________ (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:

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Prescriber's Name: ________________________

Prescriber ID: ____________________________

Prescriber's Signature: _____________________

Signature Date: ___________________________

Affix Controlled Prescription Program form here