

PHARMACIST DRUG THERAPY RECOMMENDATION
PRESCRIBER RESPONSE REQUESTED



The pharmacist has reviewed this patient and attempted to determine drug therapy solutions that may better help the patient. Please find the recommendation below and please respond as to whether you accept this recommendation.

PHARMACEUTICAL OPINION OUTCOME

Change to Rx

Not Filled

No Change to Rx

PATIENT INFORMATION

Name:

Phone:

DOB:

PRESCRIBER INFORMATION

Name:

Phone:

Fax:

IDENTIFIED DRUG RELATED PROBLEM

Details & Rationale:

Dose too high

Dose too low

Drug not as effective as needed

Non-compliance

Patient needs additional drug therapy

Therapeutic duplication

Adverse drug reaction

Pharmacists Recommendation & Follow-up Plan:

ATTENTION: PRESCRIBER

Pharmacy Use/Information

Check one of the following:

Accept recommendation

Other (please advise)

PRESCRIBER SIGNATURE:

Fax:

Phone:

Address:

Date:

RPh Name:

RPh Signature:

Please fax back to pharmacy

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