PHARMACIST DRUG THERAPY RECOMMENDATION
PRESCRIBER RESPONSE REQUESTED

HDPhA

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

☐ **Dose too high**
☐ **Dose too low**
☐ **Drug not as effective as needed**
☐ **Non-compliance**
☐ **Patient needs additional drug therapy**
☐ **Therapeutic duplication**
☐ **Adverse drug reaction**

Details & Rationale:

Pharmacists Recommendation & Follow-up Plan:

ATTENTION: PRESCRIBER

Check one of the following:

☐ **Accept recommendation**
☐ **Other (please advise)**

PRESCRIBER SIGNATURE:

Please fax back to pharmacy

Pharmacy Use/Information

Fax:
Phone:
Address:
Date:
RPh Name:
RPh Signature: