**Healthcare Provider Notification of Prescription Adaptation**

**Note to Prescribers:** This communication is for your information only to update your patient medical records.
No response is required.

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| **Patient Information** |  |
| Patient last name:      | Patient first name:       |
| OHIP #       | Date of Birth:      |
| **Pharmacy Information** |
| Pharmacist name:      | Pharmacist OCP #:      |
| Pharmacy Telephone:      | Pharmacy Fax Number:      |
| **Prescriber Information** |
| Prescriber Name:      | Prescriber License #:      |
| Prescriber Telephone:      | Prescriber Fax Number:      |
| **Adapted Prescription Information** |
| **Original Rx From Prescriber** | **Pharmacist-Adapted Rx** |
| **Prescribed Drug:** (Note that the drug itself cannot be adapted)      |
| **[ ]  Original Dose:** (e.g. – strength)      | **Adapted dose:**      |
| **[ ]  Original Formulation:** (e.g. – liquid, cream, etc.)      | **Adapted formulation:**      |
| **[ ]  Original Route:** (e.g. – PO, SL, topical, etc.)      | **Adapted Route:**      |
| **[ ]  Original SIG:**       | **Adapted SIG:**      |
| **Pharmacist Rationale for Adaptation:**       |
| **Original Date Prescribed:**      | **Date of Dispensing:**      |
| **Patient/Caregiver Notified:** [ ]  Yes [ ]  No |
| Caregiver Name (If applicable):      | Caregiver Relationship:      |