**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: | |