|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **1. Patient Information** | | | | | **2. Prescriber Information** | |
| Surname | Given Name | | Gender | | Name | ID Number |
| Date of Birth | OHIP Number | | Version Code | | Office Telephone | Facsimile |
| Address | | | | | Prescriber’s One-Mail Email Address (If available from presecriber) | |
| City | Postal Code | | Telephone | |
| Other Relevant Information | | | | | Date/Time of Transmission to Prescriber: | |
| **3. Categorization of the Drug-Related Problem (DRP)** | | | | | | |
| **Pharmacist: Please check one of the following:**  Therapeutic duplication drug may not be necessary  Patient needs additional drug therapy  Drug is not working as well as needed (sub-optimal response  Dose is too low  Adverse drug reaction due to allergy or conflict with another medication or food  Dangerously high dose prescribed or patient taking too much medication (either accidentally or deliberately  Non-compliance (refusing drug or not taking it properly  False or altered prescription has been confirmed | | | |  | **Pharmacist: Please provide commentary on DRP where appropriate:** | |
| **Level of Urgency:**  **LOW  MED  HIGH** | |
| **4. Pharmacist’s Recommendation on Current DRP** | | | | | **7. Copy of Original Prescription** | |
|  | | | | | Pharmacist to affix a copy of the original Rx or previously filled Rx label here. If transmitting electronically please transcribe original prescription as originally issued by prescriber. | |
| Pharmacist Name: | | | | |
| **5. Prescriber Review and Comments** | | | | |
| Prescriber Comments/Response: | | | | |
| Prescriber Signature: | | | | |
| **6. Pharmacist Action Plan & Discussion with Patient & Comments** | | | | |
|  | | | | |
| Check here if prescriber authorization is verbal | | | | | **Pharmacy Use Only (Please check only one**    Outcome Cross Referenced Rx/Tx Number:  Rx not filled as prescribed (due to clinical issue or confirmed falsified Rx – PIN 93899991  No change to Rx; Rx filled as prescribed – PIN 93899992  Change to Rx – PIN 93899993 | |
| Pharmacist Signature: | | | | |
| OCP #: | | Date of Transaction: | | |
| Insert Logo | | | | | Insert Address | |