Collaborative Care Communication Form

TO: (Original Prescriber):_____Date:_____

Address:_____ Phone:__Fax:___

FROM: (Pharmacist):_____

Pharmacy Name:_____

Address:_____

Phone Number: _____Fax:_____

RE: Patient Name:_____

Address:_____

Phone Number:_____Alberta Health Care Number:_____

DRUG THERAPY PROBLEMS

□ Drug therapy not required

□ Needs additional drug therapy

□ Drug therapy not working

□ Drug dose too low

□ Adverse drug reaction

□ Drug dose too high

□ Noncompliance

□ Other:_____

□ ***ACTION COMPLETED*:**

Pharmacist completing action:_____

□ ***RECOMMENDATION:***

□ ***ACTION REQUESTED – Please respond to pharmacy***

Pharmacist requesting action:_____

For fax back confirmation of action:

Original Prescriber's Signature:_____**Date:**_____

□ ***INFORMATION ONLY - No Immediate Action Necessary***