Prescription adaptation notification - *no response required*

Date

From

(fill in or use store stamp)

Pharmacy name:

Address:

Phone:

Fax:

To

Prescriber:

Fax:

Regarding

Patient:

Address:

AHC #:

DOB:

Pharmacist's assessment and rationale

Information I gathered (subjective/objective) and my rationale for the adaptation:

References I checked *(if applicable)*:

Adapted therapy assessed to be:

☐ indicated ☐ effective ☐ safe
☐ Patient is willing to adhere to therapy

Follow-up and monitoring plan discussed with patient:

I have adapted this patient's prescription in the following way:

☐ Dosage change ☐ Formulation change
☐ Regimen change ☐ Therapeutic substitution
☐ Renewal for continuity of care

For renewal, attach original prescription label here or indicate the original Rx # below

Original Rx #:

The following adapted prescription was dispensed:

Date:

Drug and strength:

Directions:

Quantity:

Please refer to the attached copy of the original prescription or pharmacy label for reference.

Pharmacist name: _____

Practice permit #: _____

Pharmacist signature: _____

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