APPENDIX II
Template Pharmacist Prescribing Documentation and Notification Form A

(for use when initiating a prescription)

Patient Information:

Name _____ Date of Birth _____ MCP # _____

Documentation of Informed Consent:

The patient and/or their agent was provided with sufficient information to allow him/her to make an informed decision regarding the pharmacist prescribing and voluntarily provided his/her consent.

Consent provided by: ◯ Patient ◯ Patient's Agent: _____

Patient or Agent Signature: _____

Prescribing Details:

Prescription Date: _____ **Prescription #** *(if applicable)*: _____

Category of Prescribing:

◯ Prescription for Schedule I, II or II Drug for a Minor Ailment ◯ Prescription for Schedule II, III or Unscheduled Drug

Assessment Details: _____

Diagnosis: _____

Recommendations *(including non-pharmacological)*: _____

Pharmacist Information:

Name _____ Registration # _____

Pharmacy Name (if applicable) _____ Contact Phone # _____

Pharmacist Signature _____

Follow-Up Plan and Results

Follow-up Plan:

Desired Outcome(s):
- ◯ Condition resolved within _____days
- ◯ Other(s): _____

Planned Date/Time : _____

Method: ◯ In pharmacy ◯ By phone Phone number: _____

Follow-up Results:

Actual Date/Time: _____

Completed by: _____

Notes:
- ◯ Completed as scheduled
- ◯ Unable to reach
- ◯ Rescheduled: _____

Outcomes:
- ◯ Resolved – no further follow-up needed
- ◯ Improved
  - ☐ No further follow-up needed
  - ☐ Improved – further follow-up scheduled
- ◯ No improvement / worsened
  - ☐ Therapy changed. Further follow-up scheduled
  - ☐ Referred to primary care provider
  - ☐ Referred to emergency department
- ◯ Therapy was discontinued
  - ☐ Did not tolerate therapy
  - ☐ Was non-adherent to therapy
  - ☐ Patient consulted other health care provider

Notes: _____

Notification of Other Health Care Provider

Notification Information:

Health Care Provider Notified? ◯ Yes ◯ No

_____ (Name of Health Care Provider Notified) _____ (Phone #) _____ (Fax #)

Method of Notification: ◯ Fax ◯ Other: _____ Date Sent: _____

If Primary Health Care Provider was not notified, please document rationale:

_____

_____