

# Frequent Dispensing – Documentation/Consent/Notification Form



## Patient Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ OHIP No. or Date of Birth: \_\_\_\_\_

## Pharmacist Assessment\*

It is my professional opinion that the patient above requires a more frequent medication dispensing interval to help him/her achieve desired health outcomes, as he/she is incapable of managing his/her medication regimen as a result of a:

<input type="checkbox"/> Physical impairment <u>Nature:</u>	<input type="checkbox"/> Cognitive impairment <u>Nature:</u>	<input type="checkbox"/> Sensory impairment <u>Nature:</u>	<input type="checkbox"/> Complex medication regimen <u>Details:</u>
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The dispensing regimen will be:  
 every 7 days       every 14 days       every 28 days       Other:

*\*Regular assessment is required to verify the ongoing need for more frequent dispensing, and to determine if the patient is stabilized and capable of managing 100 day supplies.*

The rationale/reason(s) for my assessment of the clinical or safety risks to the patient if larger quantities were dispensed, is/are:

Pharmacist's name (print):	OCP #:
Signature:	Date:

## Pharmacy Information

Pharmacy Name:	Address:
Telephone:	Fax:

## Patient/Agent Consent

I consent and authorize to have my medication(s) dispensed in reduced quantities from what was originally prescribed, as per the assessment, rationale and dispensing regimen outlined above.

I consent to have this form sent to the prescriber(s).

Date:	Agent's Name (if applicable):
Patient's Signature:	Agent's Signature (if applicable):

## Prescriber Notification

Dear Prescriber: This notification is being sent to you to comply with regulations made under the Ontario Drug Benefit Act and policies under the Ontario Drug Benefit program, whereby I am required to notify you in writing with my determination and rationale noted above for your records.

Prescriber's Name:	Date of Notification (DD/MM/YYYY):
Method of Notification: <input type="checkbox"/> Fax:	<input type="checkbox"/> Other:

**This documentation is valid for a period of 365 days.  
It is required to be updated annually and, is to be maintained as part of the patient's permanent pharmacy health record.**