

Frequent Dispensing – Documentation / Consent / Notification Form

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Patient Information			
First name:		Last name:	OHIP No. or Date of Birth:
Pharmacist Assessment			
It is my professional opinion that the patient named above requires a more frequent medication dispensing interval to help achieve desired health outcomes, as he/she is incapable of managing his/her medication regimen as a result of:			
☐ Physical impairment Nature:	☒ Cognitive impairment Nature:	☐ Sensory impairment Nature:	☐ Complex medication regimen Details:
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: Medication regimen is complex and patient may occasionally forget to take medications or may take multiple doses throughout the day, resulting in potential drug-related problems. Patient is at risk for adverse health outcomes. Patient is requesting blister packs/compliance packaging to help with adherence. Additional notes: _____			
Pharmacist's name:		OCP #:	
Signature:		Date:	
Pharmacy Information			
Pharmacy name:		Address:	
Telephone:		Fax:	
Patient Consent			
I consent and authorize my medication(s) to be 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). If my medications are dispensed in compliance aid packaging, I acknowledge that the compliance aid may not be child resistant.			
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:	
Method of Notification: ☐ Fax		☐ Other: _____	

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