Request: Medication Change Communications

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Attention: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- |
| Patient Information |  |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Our mutual patient is enrolling in the pharmacy’s medication synchronization and packaging program. The program is a coordinated refill service that synchronizes all of the patient’s prescriptions so that they are refilled on the same day each month. We also package the patient’s medications by day and time in adherence packaging. In order to make sure we are appropriately packaging the patient’s medication, we request that you **please communicate any medications changes with pharmacy, *including dose changes and discontinued medications****.* We appreciate your assistance! Please feel free to call us with any questions or concerns.

Thank you,

Pharmacy Team