

Ref No.

Pharmacist-Prescriber Two-way Communication Form

To Prescriber/Pharmacy	Date
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Patient Name Address	DOB
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Code (see over)	Details

	I have spoken about this with the patient	YES / NO
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Action Taken	Repeat Dispensing Patient?
	YES / NO

Sent by GP/Pharmacist Name (Print)..... Signature..... Practice/Pharmacy Address	Pharmacy stamp
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Pharmacy Codes	
ADR	Adverse drug reaction
DI	Drug interaction
SO	Strength optimisation
II	Incomplete instructions
DM	Duplication of medicines
OTC	Concern with medicines purchased OTC
NR	Items no longer required
C	Compliance
E	Requested early
RE	Requested erratically
GB	Generic/Brand switch
RM	Returned medicines
UI	Unwanted items
O	Other
GP Codes	
IS	Item stopped
MC	Medication changed
QC	Quantity changed
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