

APPENDIX B: CONTINUED CARE PRESCRIPTION NOTIFICATION for Health care Professionals

DATE: _____

TO DR.: _____

FAX: _____

FROM PHARMACY: _____

FAX: _____

In accordance with the "Continued Care Prescribing Regulations" of the Prince Edward Island Pharmacy Act, the following prescriptions have been provided to your patient.

PATIENT: _____

PHN: _____

DOB: _____

CCP LABEL

Continuing Care Note: _____

Orig. Rx # _____

Orig. Prescriber: _____

CCP LABEL

Continuing Care Note: _____

Orig. Rx # _____

Orig. Prescriber: _____

Should the prescriber being notified of the refill wish to re-order a supply of these medications by facsimile, please fill in any changes and refill information in the space provided by the label(s) above, complete the certification below and return by fax to the pharmacy.

Prescriber Certification

- *This prescription represents the original of the prescription drug order.*
- *The pharmacy addressee noted above is the only intended recipient and there are no others.*
- *The original prescription has been invalidated or retained so that it cannot be re-issued.*

Prescriber's name: (Print name) _____ ID#: _____

Prescriber's Signature or Unique Identifier : _____ Date: _____

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