**INFORMATION SHARING FORM**

(Prescriber/CPN to Pharmacist)

|  |  |
| --- | --- |
| Patient Name |       |
| CHI or D.O.B |       |
| Doctor/CPN Name |       |
| Practice/Clinic Name |       |
| Telephone and emailcontact details |       |
| Other relevant professionals |       |
| Stage of Treatment | Initiation[ ]  Titration [ ]  Stable [ ]  Reducing[ ]  |
| Co-existing medicalconditions |       |
| Number of childrenliving with patient |       |

|  |
| --- |
| Brief Outline of Current Treatment Plan      |
| Additional Relevant Information      |
| Pharmacy Name and Details      |