**INFORMATION SHARING FORM**

(Prescriber/CPN to Pharmacist)

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| --- | --- |
| Patient Name |  |
| CHI or D.O.B |  |
| Doctor/CPN Name |  |
| Practice/Clinic Name |  |
| Telephone and email  contact details |  |
| Other relevant professionals |  |
| Stage of Treatment | Initiation Titration  Stable  Reducing |
| Co-existing medical  conditions |  |
| Number of children  living with patient |  |

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