Test & Prescribing Results Notification

To Physician / Health Care Provider: *You are receiving this form to facilitate you maintaining an accurate and complete patient record and to avoid duplication of interventions.*

Notification Information

Health Care Professional Notified:

Notification Date:

Method: ☐ Fax _____ ☐ Phone _____ ☐ Other _____

Patient Information

Name:	Health Card #:	Age:

Informed Consent provided by: ☐ Patient ☐ Patient's Agent (specify agent name) _____

Information on Test Ordered

Test Name:	Test Date:
Rationale for Test:	Test Result:

Other Details (if applicable):

Follow-up Plan (if applicable)

Therapeutic Goal	Follow-up Action(s) to be Undertaken	Date for Follow-up	Individual Responsible for Follow-up

Prescription Information (if applicable)

Prescription Date:

Prescription Details *(include prescribing category)*:

Prescribing Rationale:

Patient Communication / Instructions:

Prescribing follow-up (*if appropriate)*

Notes*:*

Pharmacist Information

Name: Phone: Fax:

Pharmacy: