



Drug Information Request Documentation Form

Date: _____ Time Received: _____ AM PM

Received by: _____

Name of Requester: _____

Requester Identity: patient pharmacist physician nurse other: _____

Preferred method of delivery: phone fax email mail References required: Y N

Phone number: _____ Fax number: _____

Email address: _____

Mailing address: _____

Response needed in: 10 min 30-60 min end of day when time permits

Question & Pertinent Background Information (including patient's medical conditions/medications, etc., where applicable):

Type of Request: Ident Ther Alt Dos/Admin Ther Use ADR DI Other
Search Strategy:

Response:

References:

Callback Attempts: Date: _____ Time: _____ AM PM Initials: _____

Date: _____ Time: _____ AM PM Initials: _____

Total Time Required: _____ min Completed By: _____