Use this form to report back to the District Quality Use of Medicines Committee or local Drug and Therapeutics Committee regarding the clinical outcome of the use of a drug in an individual patient. This form can be used to request further/ongoing supply.

**Please complete all required fields of this form electronically. Incomplete or handwritten forms will not be accepted.**

**Patient details**

Patient name:

MRN:

Weight:

Date of Birth:

Location (ward/clinic):

**Product Profile**

|  |  |
| --- | --- |
| Australian Approved (generic) Name |        |
| Trade Name |        |
| Pharmacological class and action (summary) |       |

# Indication(s) and dose

What was the indication(s) for drug use in this patient? What was the dose/ treatment regime?

|  |
| --- |
|       |

# What was the outcome of the treatment?

|  |
| --- |
|       |

# Is further treatment requested?

Please provide details of planned treatment (dose/treatment regime). Explain your reasons for requesting continuing therapy.

|  |
| --- |
|       |

# Additional comments

|  |
| --- |
|       |

# Details of Applicant

# Requested by:

|  |  |
| --- | --- |
| Name of Applicant |       |
| Position / Appointment |       |
| Contact Details(Postal address, email, telephone) |       |
| Signature |       | Date |       |

# Endorsed by (to be completed if further treatment requested):

|  |  |
| --- | --- |
| Name of Unit Head |       |
| Position / Appointment |       |
| Contact Details(Postal address, email, telephone) |       |
| Signature |       | Date |       |

**Now complete checklist** ► **Tick**

All sections of form completed (including endorsement, if required) [ ]

Supporting data attached (relevant patient results etc.) [ ]

►*Forward completed form to local Pharmacy Department*