



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 References required: Y N

Phone number: Fax number:

Email 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: