

CONSULTATION
Pharmacy Drug Regimen Review

Attending Physician _____ **Division** _____

Diagnosis(es) _____

Unit/Building _____

Reviewing Pharmacist _____ **Date** _____

Client Receiving the Following Medications:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Drug Review Issues	Action Taken

M.D. Reviewing _____

(Signature)

Date Reviewed _____

Stamp Plate

