

**FORTH VALLEY ACUTE HOSPITALS
PHARMACY SERVICES**

WS-S-712

Issue Date: Oct 06

Review Date: Oct 2010

REQUEST FOR A NON-FORMULARY DRUG

This form should be completed by the PRESCRIBER for initiation of a non-formulary drug if the drug is prescribed for this patient for the first time in this hospital. The form should then be forwarded to the responsible CONSULTANT for counter signature. The completed form should then be returned to the ward pharmacist who will file it in the pharmacy department.

Part A : Patient Details

Patient Name/Details:	Reason for admission:
Ward:	Consultant:
	Clinical pharmacist:

Part B : Drug Details

Name(generic and proprietary):		
Form:	Strength:	Dose:
Indication:		

Part C : Reason Formulary Product is not suitable

No equivalent Drug:
No equivalent Form of Administration:
More Effective:
Less Side Effects, Specifically.....
Other:

Prescriber (printed):..... Signature:.....Date:.....

Consultant (printed):..... Signature:.....Date:.....

Part D: Pharmacy Use

Price (include VAT) - per packsize: - per daily dose:
Comment:
Clinical Pharmacist (printed):
Signature: