

CYCLE MEDICATION REPLACEMENT

Patient Name: _____ DOB: _____

Facility: _____

Medication: _____ Rx #: _____

The cycle medication listed above needs to be replaced due to the following reason:

- Medication was dropped and wasted
- Medication was refused 3 times and wasted
- Medication was spit out
- Other (explain): _____

Total Quantity of replacement tablets/capsules needed: _____

PLEASE NOTE: Any controlled substance must have an approval from the prescriber before any additional medication can be sent out.

Facility Staff Name (print)

Date

FAXED TO MHP: _____

Date and Initials

PLEASE COMPLETE AND FAX TO PHARMACY AS SOON AS POSSIBLE

PHI HIPAA Compliance Statement

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