



Patient Information Modification Form

Personal information on this form is collected under the *Pharmaceutical Information Act* and Regulations. This information is required in order to process information modification in the PhIP. If you have questions in relation to this form please contact PEI Pharmacare at (902) 368-4947.

Remove/Modify Information From the Following Patient's Profile:

Surname:	First Name:	Initial:
Date of Birth (DD/MM/YYYY):		PHN:

Information to be Modified (if multiple, please use second page)

Drug name, DIN, date of dispense:

Reason for modification:

Is this information to be moved to another patient? _____ Yes _____ No

If yes, please enter the correct patient's information:

Surname:	First Name:	Initial:
Date of Birth (DD/MM/YYYY):		PHN:

Pharmacy Name:	Date:	Pharmacist Name (Please Print):
Pharmacy Address:	Pharmacy Tel:	Pharmacist Signature:

OFFICE USE ONLY

Date Modified:

OFFICE USE ONLY

Modified by:

PLEASE SEND COMPLETED AND SIGNED MODIFICATION FORM TO:

**PEI Pharmacare
P.O. Box 2000 Charlottetown, PE C1A 7N8
Fax: (902) 368-4905
Email: drugprograms@gov.pe.ca**

#2

Drug name, DIN, date of dispense:

Reason for modification:

#3

Drug name, DIN, date of dispense:

Reason for modification:

#4

Drug name, DIN, date of dispense:

Reason for modification:

#5

Drug name, DIN, date of dispense:

Reason for modification:

#6

Drug name, DIN, date of dispense:

Reason for modification:

#7

Drug name, DIN, date of dispense:

Reason for modification: