

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)368-6338.

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	OFFICE USE ONLY
Date Modified:	Modified by:

SEND COMPLETED AND SIGNED MODIFICATION FORM TO:

**Pharmaceutical Information Program
P.O. Box 2000 Charlottetown, PE C1A 7N8
Fax: (902) 368-4905**

#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: