

Date\_\_\_\_\_\_\_\_\_

To: (First, Last Name – Credentials)

Office Practice, Address

Re: (Patient Name, DOB)

Dear \_\_\_\_\_\_,

It is our goal to be your partner and the purpose of this communication is to make sure we are working together in the care of this patient.

This is a communication regarding the controlled substance prescriptions for the following patient:

Patient (---Name, DOB---)

Medication, Strength, Dose, Quantity) exceeds the recommended daily oral morphine equivalent (mme) dose of 90mg.

* (Optional) Additionally, this patient’s record indicates the use of benzodiazepines in conjunction with opioids.

Attached is this patient‘s prescription history indicating long term treatment at these doses. In order to meet our standards of practice it is important that we have an understanding of this patient’s current condition and plans for how the controlled substances will be managed moving forward. It is our goal to continue to care for this patient, but we need to be comfortable with the care plan to continue in that capacity. As pharmacists we have a duty to ensure that patients are receiving medication regimens that are safe and appropriate for their medical condition.

To better understand the care plan for this patient, please provide the patient’s diagnosis.

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check all that apply:

* This patient has established care at my office and is stable on current regimen.
* This patient is currently enrolled in a pain management program and medications are being adjusted.
* This patient is currently weaning off opioid medications
* This patient is new to my practice.
* Controlled substance agreement is in place

Thank you. If you have any questions or we can be of any assistance, please do not hesitate to contact us at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Professionally,

Pharmacist/Pharmacy