MEDICINES SHORTAGE FORM

Pharmacy stamp/label. Name of community pharmacist	

Date	

Name of prescriber	
Name of practice	

We are currently unable to supply the following medication for your patient named below.

Patient name	
Patient DOB	
Usual prescription	
Current supply issue	
Expected duration of supply problem	

Please could you issue a prescription for the item below, which I would consider to be a suitable alternative. Please prescribe for 28 days to reduce medicines wastage.

Suitable alternative available	

We will speak to the patient to ensure they understand the change in medication and the reason for the change.

Thank you for your help.