**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.