

PRESCRIPTION PROFILE TRANSFER FORM

Managed Health Care Services Inc.



If your prescriptions are not currently filled at **Lawtons Drugs** or **Sobeys Pharmacy**, please complete this form and present it to the pharmacist at the **Lawtons Drugs** or **Sobeys Pharmacy** of your choice, along with your **MHCSI Drug Card**.

The information on this form helps the pharmacist provide you with the many professional services you receive with each prescription filled, including the review of your medical and medication history to detect and prevent possible drug interactions, duplicate therapies, allergies and other related complications. The information provided is kept strictly confidential by the pharmacy, and is used only for the purposes of providing you with the best health care possible.

MHCSI # CLIENT/FAMILY #	EMPLOYEE	DEPENDENT CHILDREN (IF MORE THAN 3, PLEASE USE ADDITIONAL FORM(S))			SPOUSE (IF APPLICABLE) <i>Spouse's signature is required to complete this section of the form</i>
Last Name					
First Name					
Patient #					
Street Address		<input type="checkbox"/> If same as employee	<input type="checkbox"/> If same as employee	<input type="checkbox"/> If same as employee	<input type="checkbox"/> If same as employee
City/Town/Province					
Postal Code					
Mailing Address (if different from above)					
Telephone # (Home)		<input type="checkbox"/> If same as employee	<input type="checkbox"/> If same as employee	<input type="checkbox"/> If same as employee	<input type="checkbox"/> If same as employee
Telephone # (Work)		<input type="checkbox"/> If not applicable	<input type="checkbox"/> If not applicable	<input type="checkbox"/> If not applicable	<input type="checkbox"/> If not applicable
Birthdate					
Current Weight					
Medication (or other) Allergies					
Medical Conditions					

Continued on reverse

CONT'D	EMPLOYEE	CHILD:	CHILD:	CHILD:	SPOUSE
Prescription Medications					
Non-prescription Medications (including herbal and homeopathic) Regularly Used					
Do you currently smoke cigarettes? (Cigarette smoke can affect how some medications work)	<input type="checkbox"/> Yes (_____ per day) <input type="checkbox"/> No (quit for _____) <input type="checkbox"/> I've never smoked	<input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	<input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	<input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes (_____ per day) <input type="checkbox"/> No (quit for _____) <input type="checkbox"/> I've never smoked <input type="checkbox"/>
Do you drink alcohol? (Alcohol can interact with some medications)	<input type="checkbox"/> I don't drink alcohol <input type="checkbox"/> 1-2 drinks/day <input type="checkbox"/> 1-2 drinks/week <input type="checkbox"/> 1-2 drinks/month or less <input type="checkbox"/> 3 or more drinks/day	<input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	<input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	<input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	<input type="checkbox"/> I don't drink alcohol <input type="checkbox"/> 1-2 drinks/day <input type="checkbox"/> 1-2 drinks/week <input type="checkbox"/> 1-2 drinks/month or less <input type="checkbox"/> 3 or more drinks/day
How do you usually feel?	<input type="checkbox"/> Good <input type="checkbox"/> OK <input type="checkbox"/> Under the weather <input type="checkbox"/> Sick	<input type="checkbox"/> Good <input type="checkbox"/> OK <input type="checkbox"/> Under the weather <input type="checkbox"/> Sick	<input type="checkbox"/> Good <input type="checkbox"/> OK <input type="checkbox"/> Under the weather <input type="checkbox"/> Sick	<input type="checkbox"/> Good <input type="checkbox"/> OK <input type="checkbox"/> Under the weather <input type="checkbox"/> Sick	<input type="checkbox"/> Good <input type="checkbox"/> OK <input type="checkbox"/> Under the weather <input type="checkbox"/> Sick
Have you ever had to stop taking a medication because of an unwanted side effect?	<input type="checkbox"/> No <input type="checkbox"/> Yes, please describe:	<input type="checkbox"/> No <input type="checkbox"/> Yes, please describe:	<input type="checkbox"/> No <input type="checkbox"/> Yes, please describe:	<input type="checkbox"/> No <input type="checkbox"/> Yes, please describe:	<input type="checkbox"/> No <input type="checkbox"/> Yes, please describe:
When you take a medication, do you:	<input type="checkbox"/> Always take it as instructed <input type="checkbox"/> Usually take it as instructed <input type="checkbox"/> Miss a few doses <input type="checkbox"/> Take it sometimes, if you remember	<input type="checkbox"/> Always take it as instructed <input type="checkbox"/> Usually take it as instructed <input type="checkbox"/> Miss a few doses <input type="checkbox"/> Take it sometimes, if you remember	<input type="checkbox"/> Always take it as instructed <input type="checkbox"/> Usually take it as instructed <input type="checkbox"/> Miss a few doses <input type="checkbox"/> Take it sometimes, if you remember	<input type="checkbox"/> Always take it as instructed <input type="checkbox"/> Usually take it as instructed <input type="checkbox"/> Miss a few doses <input type="checkbox"/> Take it sometimes, if you remember	<input type="checkbox"/> Always take it as instructed <input type="checkbox"/> Usually take it as instructed <input type="checkbox"/> Miss a few doses <input type="checkbox"/> Take it sometimes, if you remember
Any other relevant information to assist your care? (e.g. packaging, labeling needs, etc.)					

Employee's Signature: _____

Date: _____

Spouse's Signature: _____

Date: _____

COORDINATION OF BENEFITS

Do you and/or your family have drug benefit coverage through another carrier?

- Yes
 No

If yes, your plans will be co-ordinated according to the industry standards

Spouse employed by: _____
and Insured by: _____

PHARMACY USE ONLY

Profile reviewed by: _____

, PhC.

Date reviewed: _____

