MACOMB COUNTY COMMUNITY MENTAL HEALTH

DRUG UTILIZATION REVIEW

CLARIFICATION REQUEST

Date: _____

To: _____ Program/Service Unit: _____

Patient Name: _____ Case # _____

RE: Medications Ordered:

1) _____ # _____

Directions: _____ RX Date: _____

2) _____ # _____

Directions: _____ RX Date: _____

3) _____ # _____

Directions: _____ RX Date: _____

In reviewing the above medications prescribed for your patient, clarification is requested regarding

□ **Pharmacoeconomics** □ **Polypharmacotherapy** □ **Other**

PLEASE CLARIFY THE FOLLOWING:

_____

_____

_____

PHYSICIAN RESPONSE

Please **PRINT** clearly. You may write on the back if needed.

_____

_____

_____

_____

_____

_____

_____

Physician Signature/Date

(Name of Chief Medical Officer, credentials)

Pease send your response by_____ mail or fax to**:**

22550 Hall Road
Clinton Twp, MI 48036
Tel: (586) 465-8323
Fax: (586) 469-7674