COMPLIANCE PACKAGING PRIOR APPROVAL FORM

Ministry of Health

Drug Plan & Extended Benefits
2nd Floor – 3475 Albert St.
Regina, SK S4S 6X6

DATE: _____

MEDICATION ASSESSMENT and COMPLIANCE PACKAGING REQUEST

***Only Home Care/Regional Mental Health Clients/ Group Home Clients are eligible**
***Must be completed by a Home Care Assessor, Mental Health Assessor or Pharmacist**

PATIENT IDENTIFICATION

HEALTH SERVICES NUMBER _____

NAME _____

DATE OF BIRTH _____ **Male:** ☐ **Female:** ☐

GROUP HOME ADDRESS:
(Required for CLSD licensed Group Home and Approved Private Service Home (APSH) clients) _____

HOME CARE/MENTAL HEALTH/GROUP HOME INFORMATION

The above named client requires Compliance Packaging Services based on the following:

☐ **Home Care Assessment** ☐ **Mental Health Assessment** ☐ **Pharmacist Assessment**
(for CLSD group home and APSH clients only).

_____

_____
Notes/Comments

☐ **HOME CARE ASSESSOR** ☐ **MENTAL HEALTH ASSESSOR** ☐ **PHARMACIST**

NAME _____
PLEASE PRINT

SIGNATURE _____ **DATE** _____

Home Care/Mental Health Assessor to Complete	Pharmacist to Complete
Region: _____ *PLEASE PRINT*	**Pharmacist Name:** _____ *PLEASE PRINT*
Position: _____ *PLEASE PRINT*	**Pharmacy:** _____ *PLEASE PRINT*
Phone Number: _____	**Phone Number:** _____
Fax Number: _____	**Fax Number:** _____
PLEASE FAX REQUEST TO PHARMACY	PLEASE FAX REQUEST TO DRUG PLAN AND EXTENDED BENEFITS BRANCH @ 306-798-1089

DRUG PLAN USE ONLY

Fax Back Information: