New Brunswick College of Pharmacists
Ordre des pharmaciens du Nouveau-Brunswick

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PHARMACY ALERT

Effective date (YY/MM/DD): . . . .

☐ All applicable fields below must be filled in. Incomplete forms will not be processed.

Section 1: Patient Information

☐ This is a new restriction

☐ Cancellation (*Patient is no longer restricted)*

First name: . . . . Middle name(s) or initial(s): . . . .

Last Name: . . . .

Address: . . . . City: . . . . Province: . . . .

Postal Code: . . . . Telephone: . . . .

Date of Birth: . . . .
Year Month Day

Medicare number: . . . .

Your Medicare card is the most reliable piece of information to link your medication histories from all community pharmacies in New Brunswick. (www.gnb.ca)

Section 2: Restriction Information

Pharmacy name:

. . . .

Pharmacy Certificate of Operation number: **P** . . . .

Address: . . . . City: . . . .

Contact telephone number for clarification or questions if required: . . . .

Patient's Physician is or was: . . . .

Reported by (pharmacist / physician): . . . .

Pharmacist / Physician's Signature: . . . .

Section 3: Patient Consent

I, (patient name) .... agree to the restriction(s) listed above, which shall take effect immediately until further notice of cancellation. I understand and agree the information on this form will be shared with the New Brunswick College of Pharmacists and with other pharmacies in New Brunswick for the purposes of this restriction.

. . . .
Signature of patient

REFER TO THE NBCP WEBSITE FOR THE MOST RECENT VERSION OF THIS DOCUMENT