

DUAL PATIENT ASSESSMENT CHART

PATIENT INFORMATION

NAME:

PHARMACIES:

PHYSICIAN(S) WRITING PRESCRIPTION(S):

(NAME, DRUG(S) PRESCRIBED, & CONTACT INFORMATION FOR EACH M.D.)

A. _____

B. _____

C. _____

D. _____

E. _____

F. _____

G. _____

(Enter appropriate letter in column 2 below for prescriber of each drug. Add letters if necessary.)

DIAGNOSES:

- Psychiatric

- Medical

PDP INFORMATION

PLAN NAME:

MEDICAL DIRECTOR:

TOLL-FREE NUMBER FOR CUSTOMER SERVICES:

WEBSITE:

CONTACTS FOR:

- PDP TRANSITION POLICY _____

- FORMULARY INFORMATION _____

- UTILIZATION MANAGEMENT _____

- MEDICATION THERAPY MANAGEMENT PROGRAM _____

- PROVIDER RELATIONS _____

- ENROLLEE RELATIONS _____

PARTICIPATING PHARMACIES:

