Prescription Drug Review Checklist

Date: **[Insert Date]**

Prescriber: **[Insert Prescriber's Name]**

Patient: **[Insert Patient's Name]**

Medication: **[Insert Medication Name]**

Checklist

- Verify patient's current medications
- Assess potential drug interactions
- Review allergy history
- Evaluate renal and hepatic function
- Assess appropriateness of prescribed dosage
- Document indication for the medication
- Check for adherence issues
- Ensure appropriate follow-up plan is in place

Additional Notes

[Insert any additional notes or considerations]

Prescriber Signature

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[Insert Prescriber's Name and Title]