Parenteral Drug Monograph Modification Request Form

Specify Monograph:

Generic Name & Strength	
Brand Name	
Dosage Format & Route of Administration	
Adult &/or Pediatric monograph	

Describe the request for modification :

_____
_____
_____
_____
_____

Copy of attached example provided : ☐ Yes ☐ No ☐ N/A

Requested by: _____ Hospital/Unit: _____

Supervisor/designate signature:_____ Date: _____

Please forward request to: Pharmacy Admin Assistant, Regional Pharmacy & Therapeutics Committee
c/o Sharon Warkentine
swarkentine1@southernhealth.ca
Fax #: (204) 822-2649

For Regional Pharmacy & Therapeutics Committee Use Only

Date Received:	**Date Reviewed:**

Modification Approved : ☐ **Yes** ☐ **No**

Comments/Reason for Denial: _____

Committee Chair: _____ **Signature:** _____
(Print)

☐ Parenteral Drug Monograph Masters Updated Date: _____

☐ Distributed to all Manual Holders & Updated Portal & email sent Date: _____

☐ Auto-response email confirmation received Date: _____

☐ Original: Master File-Admin Support