PrEPStart Prescription Form

To physicians: Please completely fill out all of the information below to ensure that the patient's prescription can be filled and shipped.

Patient name: ____________________

Patient address: ____________________

____

place patient label here

Patient phone: ____________________

Gender Identity:

- ☐ male
- ☐ female
- ☐ transman
- ☐ transwoman
- ☐ non-binary
- ☐ other: ____________________

Date of birth (YYYY-MM-DD): ____________________

Date: ____________________

- ☐ I have completed an HIV test for the above-named patient which is negative (through Public Health Ontario)
- ☐ I have completed a creatinine for the above-named patient and the eGFR is greater than 60 mls/min
- ☐ **YES**. I have counselled the patient on the medication
- ☐ **NO**. I would like the pharmacist to contact the patient to counsel on the medication

Please list any other prescription medications this patient is taking:

RX

Tenofovir/emtricitabine (300/200mg) one tablet po daily

Mitte: 90 day supply

Physician Name:

Physician Address:

ADDRESS LINE 1

ADDRESS LINE 2

CITY

POSTAL CODE

CPSO Number:

Signature:

PLEASE SEND COMPLETED FORM TO MAPLE LEAF MEDICAL PHARMACY — FAX: 416-926-9898 • PHONE: 416-926-9696