



Date:_____

Dear:_____

Based on the 2015 Beers Criteria, one of the medications prescribed for your patient is considered high-risk for elderly patients. In efforts to reduce preventable adverse effects in the elderly we are focusing on strategies for meeting this quality measure and would like to suggest a medication change.

Patient Name:_____ Date of Birth:_____

Prescribed medication and dose:_____

Prescribed directions:_____

Beers Criteria concern:

- ☐ Anticholinergic effects
- ☐ Orthostatic hypotension / Fall risk
- ☐ Reduced elimination
- ☐ Other:_____

Suggested medication change

Drug and dosage:_____ Quantity:_____

Directions:_____

- ☐ I do not wish to change the prescribed medication
- ☐ I authorize the suggested medication change by KTA Pharmacy and authorize this fill plus_____ additional refills.

Provider signature:_____ Oral code:_____ Date:_____

Please fax to KTA Puainako Pharmacy at (808) 959-7559

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