



**PHARMACY DEPARTMENT
 INTERIM APPROVAL FORM FOR OFF-POLICY MEDICATION REQUEST**

1. PATIENT INFORMATION	2. MEDICATION DETAILS
Name: Registration No: Age: Gender: Ward: Date:	Name (Generic/ Innovator): Dose and Duration of Treatment: Diagnosis/ Indication for Use:
3. SPECIALIST'S STAMP & SIGNATURE	4. HEAD OF DEPARTMENT'S STAMP & SIGNATURE
5. PHARMACIST'S REVIEW	6. MEDICAL SOCIAL WORK DEPARTMENT (JKSP) OFFICER'S REVIEW
Current price per unit: RM _____ a) Estimated quantity used: _____ Estimated cost: RM _____ b) Quantity used: Total cost: RM _____ Stamp & Signature:	Patient's ability to pay treatment cost: <input type="checkbox"/> Approved 100% <input type="checkbox"/> Approved with conditions (Patient pays RM _____) *Please attach approval letter <input type="checkbox"/> Not approved (Reason): _____ Stamp & Signature:
7. I, _____, I/C No. _____ acknowledge that this medicine is for off-policy use. If funding (if there any) is insufficient, I agree to fully pay the medication.	
Patient/ Next of kin's signature * _____ Name: I/C No: Witnessed by: _____ Name: I/C No:	Doctor's signature _____ Name: Official Stamp:
* Please delete which is not applicable	

