NO More Seizures.org

HELP ENSURE NO CHANGES ARE MADE TO MY MEDICATIONS.

Dear Pharmacist:

Thank you for providing me with the valuable service of filling my needed prescriptions. The purpose of this letter is to let you know that I have epilepsy and it is vital that I receive the same medication from the same manufacturer monthly in order to maintain the expected level of seizure control and side effects. Please ensure that no changes are made to my medications, including a change in manufacturer, without prior consent from my physician and myself. Please note this request in my file. To assist you, I have listed below the name, manufacturer, and dosage of the medications I am currently taking.

Thank you very much,

_____ _____
Signature Todays Date

_____ _____
Printed Name Phone Number

_____ _____
Physician Name Phone Number

Brand Name _____

Generic Name _____

Manufacturer _____

Dosage_____

EPILEPSY FOUNDATION®
Not another moment lost to seizures™