**Trial Specific Prescription Review**

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| --- |
| Study Details |
| Study name |  |
| Type of study |  |
| IMP/agent name |  | Dose |  |

|  |
| --- |
| Prescription Details |
| Type of prescription (✓) | Master |  | Site specific |  | If site specific state site name |  |
| Version (date) |  |

*Note: Required content of prescription will vary according to study design, IMP formulation and risk adaption. The following table should be used as a guide. Where information is marked as n/a justification must be recorded in the comments box provided.*

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| Prescription Review |
| (✓) | Yes | No | N/A | Comments |
| Study title |  |  |  |  |
| Site name / number |  |  |  |  |
| Study identifier (e.g EudraCT number, site R&D number) |  |  |  |  |
| Sponsor |  |  |  |  |
| Patient details (name, address, date of birth, hospital identifier, known allergies) |  |  |  |  |
| Subject ID number |  |  |  |  |
| Visit Date/Number |  |  |  |  |
| Name of IMP/agent prescribed including form & strength |  |  |  |  |
| Dose of IMP/agent prescribed |  |  |  |  |
| Quantity of IMP/agent to dispense |  |  |  |  |
| Pack numbers of IMP/agent to dispense |  |  |  |  |
| Eligibility confirmation |  |  |  |  |
| Prescribers signature and date |  |  |  |  |
| Prescriber contact details |  |  |  |  |
| Professional / clinical check (initials and date) |  |  |  |  |
| Dispensed by (initials and date) |  |  |  |  |
| Checked by (initials and date) |  |  |  |  |
| Collected by (initials, date and time) |  |  |  |  |
| Additional requirements *(please list)*: |  |  |  |  |

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| Review Completion |
| **If** **master prescription**, content approved by NHSL pharmacy? (✓) | Yes |  | No |  | N/A |  |
| Comments |  |
| Final prescription version approved |  |
| Name of reviewer |  |
| Signature |  | Date |  |