After completing this page scan and e-mail it to tapering@regenboogapotheek.com or fax it to Regenboog Apotheek: +31 - 85 273 6129

Request form for a free TAPERING RECOMMENDATION

I, ☐ doctor or ☐ patient (cross box) would like to receive a recommendation for a tapering schedule for the following patient, with the following specifications:

Patient was prescribed . . . . . (fill in medicine for tapering)
for the following indication: . . . . . .
Patient is currently free from symptoms: ☐yes ☐no (cross box)
The reason(s) for tapering is/are: . . . . . .

Please check all applicable boxes:

1a. Risk factor:

☐ missed dose	: patient already had withdrawal symptoms after a single missed dose
☐ fear about tapering	: patient has indicated they are afraid of tapering
☐ past failure	: previous attempts to stop failed
☐ distinction	: there is a need to distinguish between a relapse with withdrawal symptoms or rebound
☐ slow metaboliser	: the lowest dose already yields a high plasma concentration
☐ high dose	: the dose was more than 100% of the DDD for over 6 months
☐ start	: there were problems with effects/side effects at the start of treatment
☐ previous switch	: patient has previously switched psychiatric medication once in the past
☐ other.	

1b. Duration of medicine use: ☐ <1 year ☐ 1-2 years ☐ 2-5 years ☐ 5-10 years ☐ >10 years

1c. Current usage of medicine:

. . . , . . mg time of day . . . ☐ tapering desired final dose . . . , . .
. . . , . . mg time of day . . . ☐ tapering desired final dose . . . , . .
. . . , . . mg time of day . . . ☐ tapering desired final dose . . . , . .
. . . , . . mg time of day . . . ☐ tapering desired final dose . . . , . .

1d. Other oral medication:

. . . . . (name) . . . , . . mg per day
. . . . . (name) . . . , . . mg per day
. . . . . (name) . . . , . . mg per day
. . . . . (name) . . . , . . mg per day
. . . . . (name) . . . , . . mg per day
. . . . . (name) . . . , . . mg per day

1e. Other information: . . . . . .

1f. Tablets are the desired form of administration ☐ yes (cross box)

1g. Tapering period desired by the patient: . . . . months (number)

1h. Patient consents to information transfer with local pharmacy: ☐ yes (cross box)

Local pharmacy: . . . . . .

1i. Health insurance company: . . . . . .

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2. Patient's initials and name: . . . . . .

Date of birth (DD-MM-YYYY): . . - . . - . . . . Gender: ☐ M / ☐ F Social Security No: . . . . . .

Street name and house number: . . . . . .

Postcode and city: . . . . . Country: . . . . . .

E-mail address **(mandatory)**: Telephone: . . . . . .

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3. Name of prescribing doctor: . . . . . .

Physician registration number: . . . . . .

Street name and house number: . . . . . .

Postcode and city: . . . . . Country: . . . . . .

E-mail address **(mandatory)**: Telephone: . . . . . .

I hereby confirm that all requested information has been provided truthfully.

Date: Doctor's stamp (if requested by doctor):

Applicants signature: