After completing this page, fax it to Regenboog Apotheek on +31-(0)85-2736129
or scan and e-mail it to tapering@regenboogapotheek.com

Request form for TAPERING RECOMMENDATIONS

TAPERINGSTRIP™

I, ☐ doctor or ☐ patient (tick applicable box) **would like to receive a recommendation for a tapering schedule for** ..... (medicine) **for the following patient, with the following specifications:**

Patient had the medicine prescribed for the following indication: . . . . . .
Patient is currently free from symptoms: ☐yes ☐no (tick applicable 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 (tick applicable box)

1g. Tapering period desired by the patient:

. . months (number) or
☐ 10% per week (=30% per month)
☐ 15% per week (=50% per month)

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

Local pharmacy: . . . . . .

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

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

Date of birth: . . - . . - . . . . Gender: ☐ M / ☐ F Social Security Number: . . . . . .

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

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

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

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

Medical registration number: . . . . . .

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

Postcode and city: . . . . . .

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

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

Date: Doctor's stamp (preferred):

Doctor's or patient's signature:

Mailing address: Regenboog Apotheek, Reply Number 16500, 4840 WJ BAVEL, The Netherlands