Connecticut Valley Hospital Food Drug Communication Form
Complete form and fax to the Clinical Dietician at 262-5002

Patient Name _____ Location_____

Date Therapy Started _____ Drug Name (Please check all that apply):

o Amiloride

o Antidiabetic agent: Drug Name _____

o Ciprofloxacin

o Isoniazid

o Lithium

o Lurasidone

o Lipid lowering drug: Drug Name _____

o Minocycline

o Monoamine-oxidase inhibitor

o Orlistat

o Phenytoin

o Potassium-depleting diuretics: Drug Name _____

o Tetracycline

o Verapamil

o Warfarin

o Ziprasidone

o Other: Drug Name _____

Drug Strength _____ Dosage Form _____ Regimen _____

Pharmacist _____ Date _____

REVISED: 09/97; 04/00; 3/15/03, 11/14/06, 5/11/09, 01/30/11, revised 10/25/12; reviewed 2/25/14, 12/14/15; revised 08/21/17