TACHÉ PHARMACY
Phone (204) 233-3469
Fax: (204) 231-1739
info@tachepharmacy.com

Dear Families, Residents and Staff,

Thank you for choosing Tache Pharmacy, a PharmaChoice Pharmacy, as your preferred pharmacy. We look forward to forming a strong relationship with the residents and nursing staff at The Residences with the mutual goal of optimizing medication therapy and promoting health. We are your provider for all prescription and over-the-counter medication needs. We also have after-hours service which is available 24/7/365 for pharmaceutical questions and ordering medication after-hours in times of emergencies.

To start the registration process, please complete the attached forms;

1. Resident Information (Form #1)
2. Central Fill Consent (Form #2)

Should you have any questions regarding this package, please feel free to contact Tache Pharmacy at info@tachepharmacy.ca. Our hours of operation are as follows: Monday to Friday 9 am – 6 pm.

Kindest Regards,

Alanna Kukura, RPhT & Michelle Glass B.A., BscPharm

Pharmacy Owners

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Form 1, Resident Information

Retirement Home

Name ______________________________

Room ___________

Physician

Name ______________________________

Phone ______________________________

Resident

First Name ______________________________

Last Name ______________________________

Sex: M ______ F ______

DOB (mm/dd/yyyy) ______________________

PHIN (9 digit)

__ __ __ – __ __ __ __ – __ __ __

Power of Attorney (If other than self)

For Finance

Name ______________________________

Relationship ____________________________

Primary Phone __________________________

Alt Phone __________________________

Address

____

____

____

For Care

Name ______________________________

Relationship ____________________________

Primary Phone __________________________

Alt Phone __________________________

Address

____

____

____

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Form 1, Resident Information - continued

Current Pharmacy Provider Information

Name ______________________________

Address ____

Phone ______________________ City ____________________________

HEALTH INFORMATION

Allergies:

____

____

____

Current Medical Diagnosis & History:

____

____

____

____

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Form 2, Consent to Disclose Personal Health Information

I, ______________________________ (Print your name), authorize Tache Pharmacy to disclose my personal health information for the consisting of:

Prescription records, related health conditions, lab test results relating to prescribed

medication, **For the purposes of filling prescriptions with compliance aids** OR

The personal health information of ______________________________ (Name of person for whom you are the substitute decision maker*) consisting of:

Prescription records, related health conditions, lab test results relating to prescribed

medication, **For the purposes of filling prescriptions with compliance aids**

To: Tache Pharmacy, 101-400 Tache Ave Winnipeg, MB (where all medications are blistered/packaged)

I understand the purpose of disclosing the personal health information to the company

noted above.

My Name: ____

Signature: ____ Date: _________________

Witness Name: ____

Signature: ____ Date: __________________

***Please note: A substitute decision maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.**