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):

- Amiloride
- Antidiabetic agent: Drug Name ________________________________
- Ciprofloxacin
- Isoniazid
- Lithium
- Lurasidone
- Lipid lowering drug: Drug Name ________________________________
- Minocycline
- Monoamine-oxidase inhibitor
- Orlistat
- Phenytoin
- Potassium-depleting diuretics: Drug Name _________________________
- Tetracycline
- Verapamil
- Warfarin
- Ziprasidone
- 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