〇〇〇〇年〇〇月〇〇日

[宛先]

**疑義照会Fax**

|  |  |  |  |
| --- | --- | --- | --- |
| **診療科** |  | **処方医** |  |
| **連絡先** |  | **FAX番号** |  |

**【患者情報】**

|  |  |  |  |
| --- | --- | --- | --- |
| **患者ID** |  | **患者氏名** |  |
| **診療科** |  | **発行医師名** |  |

**【薬局様情報】**

|  |  |  |  |
| --- | --- | --- | --- |
| **保険薬局名** |  | **住所** |  |
| **連絡先** |  | **FAX番号** |  |
| **薬剤師 氏名** |  |  |  |

**【処方箋情報】**

|  |
| --- |
| * 処方薬
* 用法・用量
* その他
 |

**【回答内容】**

|  |
| --- |
|  |
| 回答者： |

以上

[医師署名]：