

**Date:** [Date]

**To:** [Pharmacy Name]

**Pharmacy Fax/Email:** [Pharmacy Contact Info]

**RE: Pediatric Dosage Verification**

**Patient Name:** [Patient Full Name]

**Date of Birth:** [Patient DOB]

**Current Weight:** [Weight in kg/lbs] as of [Date Measured]

To Whom It May Concern,

I am writing to formally authorize and verify the weight-based dosage for the following medication prescribed to the patient named above:

- **Medication Name:** [Medication Name]
- **Concentration:** [e.g., 100mg/5mL]
- **Calculated Dose:** [e.g., 250mg]
- **Volume to Administer:** [e.g., 12.5mL]
- **Frequency:** [e.g., Every 8 hours]
- **Duration:** [e.g., 10 days]

I have calculated this dosage based on the patient's most recent clinical weight. Please dispense the medication as specified. Should there be any discrepancies or concerns regarding the weight-to-dose ratio, please contact my office immediately at [Phone Number].

Thank you for your assistance in ensuring patient safety.

Sincerely,

**Physician Signature:** \_\_\_\_\_

**Physician Name:** [Printed Name]

**NPI Number:** [NPI Number]

**Clinic Name:** [Clinic/Hospital Name]

**Phone Number:** [Phone Number]