



MANAGEMENT AND EMERGENCY PLAN

Authority: 1978 PA 368

Applicant's Name (First, Middle, Last)		10-Digit MI Permanent ID/License Number
Address		
City	State	Zip Code
Telephone Number	Email Address	
Date of Plan Completion	Date	

REFERRALS: List the names and addresses of at least three physicians (MD or DO), physician clinics, or hospitals in Michigan to whom you will refer patients with adverse drug reactions. Be sure at least one is skilled or specializes in the diagnosis or treatment of the eye (board eligible or certified ophthalmologist). An optometrist may include the patient's primary care physician for a physician named in the plan, but shall not substitute the patient's primary care physician for a physician named in the plan who specializes in the diagnosis and treatment of diseases of the eye.

Name of Ophthalmologist		Telephone Number
Street Address		10-Digit MI Permanent ID/License Number
City	State	Zip Code
Name of Second Referral		Telephone Number
Street Address		10-Digit MI Permanent ID/License Number
City	State	Zip Code
Name of Third Referral		Telephone Number
Street Address		10-Digit MI Permanent ID/License Number
City	State	Zip Code

PLAN: The following management plan will be in operation in my office:

1. I will refer patients with an adverse drug reaction to appropriate medical specialists or facilities.
2. I will routinely advise each patient, and so note in their record, to contact me if the patient experiences an adverse drug reaction.
3. I will place information in each patient's permanent record describing any adverse drug reaction experienced by the patient, and the date and time any referral was made.
4. A COPY OF THIS MANAGEMENT AND EMERGENCY PLAN WILL BE KEPT IN MY OFFICE.

 Signature of Applicant

 Date