Medication Therapy Services Clinic
Patient Referral Form

Phone: 709-864-2274 Fax: 709-864-6245

Date: _____

Name:

MCP:

Date of Birth:

Patient Information

Address: _____

Telephone: _____ (home) _____ (cell)

Email address: _____

Primary Care physician: ☐ Referring physician ☐ Other: _____

Does the patient know you are referring him/her to the MTS Clinic? ☐ Y ☐ N

Who should we call to arrange an appointment?

☐ Patient (contact information above) ☐ Other: _____ Relationship: _____ Phone: _____

Referring Healthcare Provider Information (Please use stamp)

Provider signature: _____

Phone: _____ Fax: _____

Reason for Referral (check all that apply):

☐ Comprehensive medication therapy assessment

☐ *NEW* Deprescribing assessment

☐ Suggest management of chronic disease or symptoms
Please specify: _____

☐ Requires education about medications
Please specify: _____

☐ Simplify medication therapy regimen

☐ Adherence issues

☐ Suspected adverse drug reaction
Please specify: _____

☐ Other:
Please specify: _____

Please provide any details/concerns which would help in our assessment: _____

_____

_____

Medical Conditions:

Cardiovascular disease: ☐ Angina ☐ Prior MI ☐ Heart failure ☐ Atrial fib ☐ Other cardiac: _____

☐ Diabetes ☐ Hypertension ☐ Dyslipidemia ☐ CVA/neurological ☐ Headache (type): _____

☐ Renal- acute ☐ Renal- chronic ☐ Depression ☐ Anxiety ☐ Insomnia ☐ Arthritis (type): _____

☐ Asthma ☐ COPD ☐ GERD ☐ Peptic ulcer disease ☐ Pain (type): _____

☐ Other: _____

Medication related issues:

Please list all community pharmacies the patient uses: _____

Other issues (check all that apply):

☐ Allergies or Medication intolerances (Please specify): _____

☐ Difficulty adhering to medications

☐ Cognitive impairment (Please specify who is responsible for medication administration): _____