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: ____

How did you hear about the MTS Clinic? ________________________________

Who should we call to arrange an appointment?

☐ Patient (contact information above)

☐ Other: ______________ Relationship: ___________ Phone: ____________

Who is Referring the Patient?

☐ Self-Referral

☐ Other: ___________________________

Relationship: _______________________

Family Doctor Name: _____________________

Phone: _____________ Fax: ______________

Reason for Referral (check all that apply):

☐ Comprehensive medication therapy assessment

☐ Deprescribing assessment

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

☐ Education about medications
Please specify: ______________________________________

☐ Simplify medications

☐ Missing doses

☐ Suspected adverse drug reaction
Please specify: ______________________________________

☐ Other:
Please specify: ______________________________________

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

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Medical Conditions:

Heart Disease: ☐ Angina ☐ Heart Attack ☐ Heart failure ☐ Atrial fib ☐ Other cardiac: _________

☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Stroke ☐ Headache (type): ________________

☐ Kidney Problems ☐ Depression ☐ Anxiety ☐ Insomnia ☐ Arthritis (type): ________________

☐ Asthma ☐ COPD ☐ Reflux ☐ Stomach ulcers ☐ 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 (Do you take your medication as prescribed?)

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

To ensure privacy and confidentiality, referrals are only accepted by fax or telephone