Referral Form

Reason for referral/current concerns:

If requesting daily witnessed ingestion, please handwrite "daily dispense" on the prescription.

Medical Conditions/Medical History

Please attach any discharge notes, admin notes, etc. available to you to help us better serve the patient.

Patient Unique Needs

☐ Cognitive	☐ Literacy
☐ Visual	☐ Swallowing
☐ Hearing	☐ Other:
☐ Language	

In the event of extreme weather or poor road conditions (ex. snow, windstorm, road closures). Is the pharmacy allowed to issue an extra supply of medications for the patient based on the discretion of the pharmacy?

☐ Yes ☐ No ☐ Other:

Referral Information:

Referred By: _____ Phone Number: _____

Email Address: _____ Fax Number: _____

Signature: _____ Date (dd/mm/yyyy): _____

Patient Demographics

Patient Name: _____ Phone: _____

Date of Birth (dd/mm/yyyy): _____ Cell: _____

Care Card Number: _____ Allergies / Intolerances: _____

Primary Language: _____ Gender: ☐ Male ☐ Female

Address: _____

Email: _____

Caregiver Information

Family/Caregiver (relationship): _____

Phone: _____ Cell: _____

Physician Information

Family Physician: _____

Phone: _____ Fax: _____

Specialist (Type): _____

Phone: _____ Fax: _____

Email: _____

Case Manager Information

Name: _____

Health Unit: _____

Phone: _____ Fax: _____

Email: _____

Please check off services required

☐ Daily witnessed ingestion of medication OR Blistering packaging	☐ Customized dosage - liquid and crushed forms
☐ Smart Blister Pack	☐ Medication review and reconciliation
☐ Smart Dispenser	☐ Medication teaching
☐ Transdermal patch application	☐ Hormone assessment tests (fee will apply, please inquire)
☐ Insulin training and injection	☐ Pharmacogenomics testing (myDNA) (fee will apply, please inquire)
☐ Prefilled syringes	☐ Other:
☐ Blood pressure monitoring; frequency:	
☐ Blood glucose monitoring; frequency:	
☐ Blood glucose monitoring teaching	
☐ Pharmacist witnessed opioid agonist treatment	

☐ **Fax weekly reports** (e.g. DWI, BP, BG, insulin doses) **to:**

Name: _____

Fax: _____

There is no additional charge to the patient for our "Pharmacy Home Monitoring Program" service.