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

Medication Management	
☐ Daily Witness Ingestion (DWI) of medication	☐ Medication Review and Reconciliation (Virtual/Visit)
☐ Blister Packaging	☐ Insulin Injection/Training
☐ Smart Blister Pack	☐ IM/SC Injection
☐ Smart Dispenser	☐ Transdermal Patch Application
☐ Opioid Agonist Treatment	☐ Other
Monitoring Services	
☐ Blood Pressure Monitoring/Training	☐ Blood Glucose Monitoring/Training
☐ Weight	☐ Other
Specialty Services	
☐ Botox	☐ Compounded Medications
☐ CSAN Pronto Testing	
☐ Biologics New Start and Switches and Patient Support Program Registration (PSP) - e.g. Adalimumab (Humira), Infliximab (Remicade), Etanercept (Enbrel), etc.	
☐ Other: _____	

☐ **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.