Referral Form

Reason for referral/current concerns:

If requesting daily witnessed ingestion, please write "daily dispense for 100 days" 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	

Emergency Carries

In the event of extenuating circumstances (e.g. extreme weather), staff may not be able to visit patient. Pharmacy will need to issue emergency carries for the patient for continuity of care, otherwise their dose will be missed.

☐ Patient authorized for 2 days worth of emergency carries to be issued at pharmacy's discretion.

☐ Patient NOT authorized for emergency carries, patient to visit pharmacy or miss their dose.

Note:

Please be aware services may take up to 2 days to process and start. In urgent cases please contact our head office directly for review.

Our services differ from Home Support Services. We only provide the care tasks listed. We are strictly education and medication management.

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: _____

If daily dispense is required, this must be indicated on each page of the prescription.
This is a Pharmacare requirement.

If patient is being discharged from hospital, please provide discharge date _____

Anticipated start date. _____ Anticipated # of Rx's. _____

Please check off services required

Medication Management *Services will be reviewed before approval*	
☐ Daily Witness Ingestion (DWI) of medication **Please handwrite daily dispense on the prescription.*	☐ Medication Review and Reconciliation (Virtual/Visit)
☐ Blister Packaging	☐ Insulin Injection/Training *conditions apply
☐ Smart Dispenser	☐ IM/SC Injection
☐ Opioid Agonist Treatment	☐ Transdermal Patch Application
☐ Other	
Monitoring Services	
☐ Blood Pressure Monitoring/Training	☐ Blood Glucose Monitoring/Training
☐ CSAN Pronto Testing	☐ Weight
☐ 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.
(some restrictions apply)