**AnyTown Medical Center  
1234 West Avenue, AnyCity 98765  
Phone: (555) 999-8888 Fax: (555) 999-7777**

**Pharmacist Referral Form**

Date: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Contact number: Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred to: **Pharmacist RPhName Surname** AnyTown Pharmacy

Phone: (555) 999-1111 9876 State Avenue, AnyCity 98765

Fax: (555) 999-2222

Referred for:

* **Medication reconciliation**: Identify and verify the list of current medications being taken is accurate and understood to avoid confusion about which drugs are the correct ones to be taken.
* **Dose orchestration**: Aligning doses and timing of doses for compatibility and optimum therapy to focus on taking medicines at the right time of day and as few times as possible.
* **Medication education**: Explaining names and purposes for medications that are being taken, and what side effects or precautions to watch for to ensure understanding of drugs and their effects.
* **Economic review of medications**: Evaluating current medications to identify appropriate but less expensive alternative treatments for relevant condition(s) and recommending changes to the physician/prescriber.
* **Therapeutic review of medications**: Evaluating current medications to identify alternative treatments with therapeutic advantages for relevant condition(s) and recommending changes to the physician/prescriber.
* **Adherence assistance**: Evaluating challenges and factors that affect patients taking their medications as prescribed and working with patients to develop strategies for improvement.

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Referring Physician: **MDName Surname, MD**

Authorizing Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_