**AnyTown Pharmacy**9876 State Ave, AnyCity 98765
Phone: (555) 999-1111; Fax: (555) 999-2222

**Medication Therapy Management
Service Provision Summary**

Date: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ Referral received: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ Service date: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_

Service Location: \_\_\_Pharmacy \_\_\_Clinic \_\_\_Patient’s home Service Duration: \_\_\_\_\_\_\_\_ mins

Drug Coverage plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Service covered: \_\_\_Yes \_\_\_No

Prescriber: **MDName Surname, MD** Phone: (555) 999-8888 Fax: (555) 999-7777

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_
Street address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_
Home #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Requested service(s): \_\_\_Medication reconciliation \_\_\_Dose orchestration \_\_\_Medication education \_\_\_Economic review of medications \_\_\_Therapeutic review of medications \_\_\_Adherence assistance \_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Issue(s) addressed:

1.

2.

3.

In addition to the provider’s initial request, the following information was also discussed:

1.

2.

Recommendations:

**RPhName Surname, RPh**
AnyTown Pharmacy

Posted\_2017.03

Prescriber Acknowledgement/Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_