FAIRVIEW PHARMACY
EST. 1978

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REFERRAL LINE 601 544 4871
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PATIENT ADHERENCE PROGRAM

Referral Form

ADHERENCE PACKAGING
Dispensing a healthy lifestyle

Please **fax the prescription** with this referral form. Kindly provide sufficient notice to ensure a timely start of service.

REASON FOR REFERRAL

Please attach any discharge summaries, admission notes, MTRs, or other supporting documents to help us better serve the patient.

PATIENT UNIQUE NEEDS

- ☐ Cognitive
- ☐ Visual
- ☐ Hearing
- ☐ Dexterity
- ☐ Swallowing
- ☐ Language
- ☐ **Other** _____

EXTRA SUPPLY OF MEDICATIONS

In the event of pandemic response, extreme weather, or poor road conditions (snow, windstorm, road closures), is the pharmacy allowed to issue an extra supply of medications based on the discretion of the pharmacist?

☐ Yes ☐ No

☐ **Conditions / Other:** _____

SIGNATURE & DATE

Referrer Signature: _____ **Date:** _____

Patient / Caregiver Signature: _____ **Date:** _____

REFERRAL INFORMATION

Referred by: _____ **Phone:** _____

Email: _____ **Fax:** _____

PATIENT DEMOGRAPHICS

Patient Name: _____ **Home Phone:** _____

D.O.B. (dd/mm/yyyy): _____ **Cell:** _____

Insurance ID #: _____ **Allergies / Intolerances:** _____

Primary Language: _____ **Gender:** ☐ M ☐ F ☐ Other

Address (with special instructions): _____

COVID-19 VACCINATION STATUS

- ☐ Fully Vaccinated
- ☐ Partially Vaccinated
- ☐ Medically Exempted
- ☐ Unknown

CAREGIVER INFORMATION

Family / Caregiver (Relationship): _____

Home Phone: _____ **Cell:** _____

PHYSICIAN / CLINICIAN INFORMATION

Family Physician / Clinician: _____

Phone: _____ **Fax:** _____

Specialist (Type): _____

Phone: _____ **Fax:** _____

CASE MANAGER

Name: _____ **Health Unit:** _____

Phone: _____ **Fax:** _____

SERVICES REQUIRED · PLEASE CHECK OFF

- ☐ Daily delivery of medications*
- ☐ Blister Packaging**
- ☐ Insulin Injection and/or Training
- ☐ Device Teaching (Inhalers, BP, Glucometers)
- ☐ Diabetes Education incl. Insulin Pump Training
- ☐ Continuous Glucose Monitoring (Dexcom G6, FreeStyle Libre)
- ☐ Medication Synchronization
- ☐ **Other:** _____

** Subject to delivery zone ** Standard service for Adherence Packaging patients*

FOR PHARMACY USE ONLY

Received by: _____ **Date Received:** _____

Pharmacist Assigned: _____ **Start Date:** _____