



## Clinical Pharmacy Services – Referral Form

Part 1: Patient/Practice Demographics		
Patient Name	Referral Date	
Patient Home #	Patient Cell/Alt #	Date of Birth
Referring Provider	Office #	Fax #
PCP	Office #	Fax #

### Pharmacotherapy Consultation (please check all that apply)

Part 2: Services Requested		
<input type="checkbox"/> Diabetes Medication Education  <i>Type of diabetes</i> <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Type 1.5  <i>Goal A1c</i> <input type="checkbox"/> < 6.5% <input type="checkbox"/> < 7% <input type="checkbox"/> < 7.5% <input type="checkbox"/> < 8% <input type="checkbox"/> Other: _____	<input type="checkbox"/> HTN Medication Education  <i>Goal BP:</i> <input type="checkbox"/> < 130/80 <input type="checkbox"/> < 140/90 <input type="checkbox"/> < 150/90 <input type="checkbox"/> Other	<input type="checkbox"/> Heart Failure Medication Education  <i>Select diagnosis:</i> <input type="checkbox"/> Systolic Heart Failure (HFrEF) <input type="checkbox"/> Diastolic Heart Failure (HFpEF) <input type="checkbox"/> Systolic/Diastolic Heart Failure
<input type="checkbox"/> Comprehensive Medication Review  <i>Includes assessment of and medication therapy optimization recommendations for prescription and non-prescription medications</i>	<input type="checkbox"/> Medication Adherence Counseling  Specific concerns: _____ _____ _____	<input type="checkbox"/> Other Medication/Condition Education or Medication-related concerns:  _____ _____ _____

### Part 3: Priority

- Normal (1-2weeks)     
  Moderate (within 5 business days)     
  High (within 3 business days)

### Part 4: Signature and Submission

Provider Signature	Date/Time	
<p>To complete referral:</p> <ol style="list-style-type: none"> <li>1. Fax this signed referral form to 203-567-8095</li> <li>2. Attached last progress note/pertinent medical records that support consultation request (non-EPIC facilities)</li> </ol> <p>Once referral is received, the patient will be contacted via phone to schedule an appointment. Referrals submitted without priority indicated will be treated as normal priority. Referrals with incomplete information cannot be completed without clarification from the referring provider. Completed consult notes will be routed to the referring provider and PCP in EPIC (or via secure fax for non-EPIC facilities) unless otherwise specified.</p>		
Hartford, CT Pharmacist Office # 860-397-1263	Springfield, CT Pharmacist Office # 860-453-0441	Waterbury, CT Pharmacist Office # 860-453-0445