FAX 306-966-6656

Phone 306-966-6392

COMPREHENSIVE MEDICATION ASSESSMENT REFERRAL FORM

1. Referring Health Care Provider Information

Name: ______________________________

Address: ______________________________

Phone: ____________________ Fax: ____________________

2. Patient Information

Name: ______________________________ DOB: ________________

Phone: ________________________ PHN: ________________

Address: ______________________________

Reason for referral: ☐ Comprehensive Medication Assessment*

☐ Other: ______________________________

Urgent request: ☐ Yes ☐ No

Is this patient currently experiencing a problem with their medications?

☐ No, Patient only requires a comprehensive medication assessment

☐ Yes, (please explain) ______________________________

Please document any specific patient medication concerns (optional):

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Please include any specialist consults or diagnostic lab results which may be applicable

3. Family Physician Information (if different from box 1)

Name: ______________________________

Clinic Address: ______________________________

Phone: ____________________ Fax: ____________________

*** See reverse for more information on what comprehensive medication management is, who can benefit, and other reasons to refer patients to MaC**