DALHOUSIE UNIVERSITY

Dalhousie School of Social Work Community Clinic
Client Referral Form for the Clinic Pharmacist
please fax: 902-494-2759 or e-mail: swcc@dal.ca

Client: _____ D.O.B: _____

IS THE REFFERAL URGENT? □Yes: _____ No

IS THE CLIENT AWARE OF THE REFERRAL? Yes No

BEST WAY TO CONTACT CLIENT TO BOOK APPOINTMENT: _____

MAY WE LEAVE A MESSAGE? □Yes: _____ No

REASON FOR REFERRAL:

□Specific medication therapy question: _____

□Medication coverage questions

□Medication optimization and education for chronic medical condition (e.g. hypertension, diabetes, asthma/COPD, pain etc.)

□Multiple medications, adherence issues or need for medication education

□Suspected adverse drug reaction

□Recently hospitalized with medication changes

□Other (please specify):

RELEVANT MEDICAL/MEDICATION/HEALTH HISTORY:

Expectations for the referral:

□ Initial assessment and recommendations back to primary care provider

□ Initial assessment, recommendations and case-management follow up with patient

DATE: _____ REFERRING PROVIDER: _____

Appointment Date: _____ Time: _____