

**REFERRAL TO:**  
**Mission Hospital Outpatient Clinical Pharmacy Services**

495 Biltmore Avenue, Asheville, NC - 28801

Phone 213-0510 - Fax 213-0151

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Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_ PCP Phone: \_\_\_\_\_

Primary Diagnosis (if known): \_\_\_\_\_

Client's Pharmacy: \_\_\_\_\_ Pharmacy #: \_\_\_\_\_

Please check if client meets the following:

- |  |  |
|--|--|
| _____ 85+ years                            | _____ Social Support Issues              |
| _____ Has barriers to primary care access  | _____ Limited access to needed resources |
| _____ Failure to thrive                    | _____ Presence of cognitive impairment   |
| _____ Multiple Emergency Department visits | _____ Change in Medication regimen       |
| _____ Poly-pharmacy                        | _____ Financial Concerns expressed       |

- How does client organize medications (pillbox, alarm, caregiver, etc.)? \_\_\_\_\_
- How often does client forget to take meds (daily, weekly, etc.)? \_\_\_\_\_
- Any other information or concerns for consulting pharmacist: \_\_\_\_\_

\_\_\_\_\_

• Current list of medications attached? \_\_\_\_\_ List compiled by: \_\_\_\_\_

Please fax/email recommendations to: \_\_\_\_\_

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Referring Physician Signature: \_\_\_\_\_ Phone: \_\_\_\_\_