IMPACT Study
Referral Form

Integrating family Medicine and Pharmacy to Advance primary Care Therapeutics

Date (yyyymmdd): [__]__]__]__] [__]__] [__]__] Site#: _____

Referring Health Care Professional: _____

Initial Referral process: □ In person □ Telephone □ Email

Patient Name: _____

Patient Address: _____

Patient Phone Number: _____

TO BE COMPLETED BY REFERRING PHYSICIAN

Reason for Patient Referral

Overall medication assessment to optimize regimen (e.g. to simplify)	□	Recent hospitalization (medication changes, monitoring needed)	□
Therapeutic dilemma	□	Suspected adverse drug event	□
Taking drug at high risk for adverse events	□	Patient medication adherence issues	□
Provide patient education about medication	□	Other (please specify:): _____	

REFERRAL OUTCOME

Please indicate on scale (by marking an 'x') the anticipated magnitude of benefit from a pharmacist assessment:

□_____|_____□

MINIMAL BENEFIT — HIGH BENEFIT

□ **NO PATIENT IS NOT REFERRED** □ **YES PATIENT IS REFERRED**

(needed for cases where referral is suggested to physician for consideration)

TO BE COMPLETED BY PRACTICE STAFF

Patient called by practice staff: □ Yes □ No

Patient agreed to be contacted by IMPACT: □ Yes □ No

TO BE COMPLETED BY IMPACT

Patient provided consent: □ Yes □ No

If possible, please book appointment: □Before: ____/____/____ □ After:____/____/____

Referral strategy: □ Case finding □ Self-referral

Date of initial assessment (appointment): ___/___/___