

Example Pharmacist Referral to Physician

Date: _____

Physician Information

Physician Name _____

ATTN: [insert nurse or support staff contact] _____

Address _____

Office Phone _____ Fax Number _____

Patient Information

Patient Name _____

Address _____

Date of Birth ____/____/____

Sex/gender: Male Female

Reason for Consultation

This patient is being referred to your practice for the following reasons: _____

Referring Pharmacist's Comments

Referring Pharmacist's Information

Pharmacist Name _____

Pharmacy Name _____

Pharmacy Address _____

Pharmacy Phone Number _____ Pharmacy Fax Number _____

Pharmacist E-mail _____

Attachments

Complete Medication List

Other (please list) _____