Medication Maven
Improving patient care through teamwork

4095 State Rd 7, Suite L-208, Lake Worth, Fl. 33449
Phone: 561-601-5002 Fax: 561-383-6460

Patient Referral Form

Referral Guidelines

1. To refer a patient for Clinical Pharmacy Services, please complete this form and return it via fax, along with a copy of the patient's most recent lab work to our Patient Services Department.

2. By submitting this competed and signed referral form to out Patient Services Department, the physician is authorizing:
a. the clinical pharmacists at Medication Maven to perform the requested services in agreement with the physician-pharmacist protocol on file, and
b. the clinical services requested are medically necessary.

3. If the patient you refer for Clinical Pharmacy Services is not seen within 28 days from the referred date, you will receive a second and final referral request to submit.

4. Please write in any special services requested in allotted sections.

Patient Information

Patient Name: _____ Date: _____

Contact/Phone Number:_____ Date of Birth: _____

Address: _____ E-mail: _____

Physician Section - PRESCRIPTION

Diagnosis:_____ Code: _____ Diagnosis: _____ Code: _____

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Clinical Pharmacy Service Requested: (check all that apply)

_____ Blood Pressure Education
_____ Cholesterol Education
_____ Diet/Nutrition Education
_____ Initial Diabetes Self-Management Education
_____ Intermediate Diabetes Self-Management Education
_____ Advanced Diabetes Self-Management Education
_____ Comprehensive Medication Review
_____ Targeted Medication Review
_____ Device Educational Services (specify below)
_____ Drug Information Services
_____ Medication Compliance Education
_____ Follow-up Educational Services (specify below)

Please specify special topics or services to cover if appropriate:

_____

Physician Signature:_____ NPI:_____ Date: _____

***NOTE** - Attach all supporting documentation such as lab work or medication lists if appropriate..

Medication Maven Patient Services Department Only

Date Received: _____ Appt. Date: _____

Clinical Pharmacist Name: _____ NPI: _____

Clinical Pharmacist Signature: _____