

Patient Information Form

FAX TO: 888-901-9286

Patient's name: _____ Facility: _____

Attending Physician: _____ Pharmacy: _____

DIAGNOSIS

- | | | | | |
|---|--|---|------------------------------------|---|
| <input type="checkbox"/> GERD | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> HIV | <input type="checkbox"/> COPD | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Peptic Ulcer Disease | <input type="checkbox"/> Arrhythmia's | <input type="checkbox"/> Infection | <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Renal Impairment | <input type="checkbox"/> CHF | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Psych / Neuro |
| <input type="checkbox"/> Edema | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Epilepsy/Convulsions | <input type="checkbox"/> CVA / TIA | <input type="checkbox"/> Alzheimer / Dementia |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Other: _____ | | | |

PATIENT INFORMATION

Date of Birth: _____ - _____ - _____ (MM-DD-YYYY)

New Admit: ☐

Gender: _____ (M / F) Current Weight: _____

Re-Admission: ☐

ALLERGIES: (Please Print Clearly)

Reason for most recent hospitalization: _____

Physician Phone: _____

Dates of hospitalization: _____

Fax: _____

INSURANCE STATUS / INFORMATION: (please check)

Medicare A ☐

Medicare D ☐

Other ☐

Explain _____

Procedure Checklist

1. Please fill out the information listed above to the best of your knowledge.
2. Please send a list of all medications, including name, strength and directions.
3. Please send any history information if available as well as the latest pain assessment if a review of pain management is needed.
4. Fax this form and all information to the fax number at the top of this page, as soon as possible.
5. You will receive a consultant pharmacist recommendation, faxed or emailed to the number you indicate below.
6. Immediately communicate this recommendation to the attending physician for potential changes. (It may be best to set this up at the time you call the physician to verify admitting orders.)
7. Please act upon the changes, and then communicate all needed information to the appropriate pharmacy.
8. If you have not received communication from the consultant pharmacist or the physician by 2pm, send all appropriate information to the pharmacy and implement subsequent changes when the current supply of medication is exhausted.

Contact Information

Name	Contact Number	Fax # for Recommendation	Date
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