



REQUEST FOR REFERRAL FOR HOME MEDICINES REVIEW

TO: General Practitioner

Name	
Address	
Phone	
Fax	
E-mail	

FROM:

Name	
Address	
Phone	
Fax	
Email	
I would be available to attend the home interview with the pharmacist <input type="checkbox"/> Please send a copy of the Medication Management Plan <input type="checkbox"/> Preferred means of receiving information: Phone <input type="checkbox"/> Fax <input type="checkbox"/> E-mail <input type="checkbox"/>	

FOR:

Patient's Name	
Address	
Phone	

Reason for referral (tick as appropriate):

- Currently taking five or more regular medications
- Taking more than twelve doses of medication per day
- Significant changes made to medication regimen in the last three months
- Medication with a narrow therapeutic index or requiring therapeutic monitoring
- Symptoms suggestive of an adverse drug reaction
- Sub-therapeutic response to treatment
- Suspected non-compliance or inability to manage drug related therapeutic devices
- Difficulty managing medication because of literacy or language difficulties, dexterity problems or impaired sight, confusion or other cognitive difficulties
- Attending a number of different doctors, both general practitioners and specialists
- Recently discharged from a facility / hospital (in the last four weeks)
- Other

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SIGNATURE: DATE:

Please consider contact with the consumer identified above to determine if they would benefit from a Home Medicines Review (HMR). If referral is deemed to be appropriate, completion of a HMR Referral form is required.