## Letter of Referral to a Community Pharmacy Primary Care Clinic- CDM

Referring to (clinic/pharmacy name):

Address:

Phone: Fax:

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| Patient Name: | Date of Birth: |
| Address: | HCN: |
| Phone: | Date: |

□ **I have permission from patient for you to contact them directly. I am referring my patient to your clinic for**:

□ Chronic Disease Management: □ Hypertension □ Cardiovascular Disease □ Diabetes □ COPD □ Asthma Other

Please indicate if any of the following CDM services are of particular need:

□ Medication Review (review of efficacy, tolerability, identify any drug therapy problems, education)

□ Prescribing new medications, medication changes for the above conditions

□ Insulin Starts □ Medication injection training

□ Continuous Glucose Monitoring New Start

□ CPAMS (Community Pharmacist-led Anticoagulation Management Service- INR testing and dose adjustments)

□ Smoking cessation

Additional Services:

□ Prescription Renewals

□ Group A Strep assessment

□ Minor Ailment Assessment for

Eligible assessments include: Mild skin conditions (impetigo, fungal infections, dermatitis, eczema, utricaria), allergic rhinitis, conjunctivitis, dry eye, general allergies, mild headache, Pinwork warts (excluding facial/genital), mild acne, oral thrush, oral ulcer, minor pain, vaginal candidiasis, hemorrhoids

□ Hormonal contraception □ Herpes Zoster Assessment □ Lyme Disease prophylaxis □Uncomplicated UTI

□ Publicly funded vaccine □ Non publicly funded vaccine □ Medication injection

□ Bloom (Community pharmacy initiative to increase/improve mental health and additions care)

□ Other:

□ **Notes**:

□ **Patient can book online at pans.ns.ca/cppcc or call the pharmacy to book an appointment with their clinic**

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|---|---|
| Provider Name: | Clinic: |
| Phone: | Fax: |