PRESBYTERIAN COLLEGE
SCHOOL of PHARMACY

Wellness Center

307 North Broad Street, Clinton, SC 29325
864-938-3930 | pcspwellness@presby.edu

REFERRAL FOR CARDIOVASCULAR RISK REDUCTION SUPPORT & EDUCATION

Patient's Full Name: _____ **DOB:** _____

Address: _____ **Phone#:** _____

Applicable Diagnoses *(circle as appropriate)*:

- AFib /Arrhythmia
- Asthma or COPD
- GERD/ Reflux
- Diabetes
- Allergies (seasonal? Y / N)
- Hypothyroidism
- Dyslipidemia
- Arthritis
- Migraine
- Heart failure
- Chronic Kidney Disease
- Neuropathy
- Hypertension
- Dementia
- Obesity
- History of MI / stroke
- Depression or anxiety
- Seizures

Frequent:
- nausea/vomiting
- constipation
- diarrhea

Other:

Referral For:

☐ **Medication Review (1 hr):** Includes pointed review of medications, medication-related problems and adherence. Referrer will receive reconciled medication list and summary of identified issues or concerns

☐ **Blood Pressure Monitoring (1 hr, initial):** Includes review of medication, home blood pressure monitoring education, and education on therapeutic lifestyle modification.

☐ **Medication Affordability Meeting (1 hr):** Includes identification of agents available through formularies, patient assistance program (PAP) or other affordable means. As applicable, referrers will receive materials with necessary guidance to help patients obtain medication(s).

☐ **Weight Reduction/Nutrition Support (1 hr, initial):** Includes review of healthy eating, physical activity, problem-solving behaviors and goal setting.

Comments: _____

_____

_____

Referring Provider's Name: _____

Referring Provider's Signature: _____ **Date:** ____/____/_____

After completing the referral form, fax to (866) 291-0649

Thanks in advance for sharing a copy of the patient's most recent labs!