Memorial Hermann Medication Therapy and Wellness Clinic – Patient Enrollment Order

Patient Name: _____ MRN: _____

DOB: ____/____/_____ Age: _____ Wt:_____ Patient Contact# _____

PHARMACOTHERAPY CONSULTATION: ☐ Med review/education ☐ Non-adherence ☐ Other: _____

DRUG THERAPY MANAGEMENT

☐ **ANTICOAGULATION – Vitamin K antagonist (Warfarin)**
INR Goal: ☐ 2.0 – 3.0 ☐ 2.5 – 3.5 ☐ Other: _____ (Greater than or equal to 0.5 units)
Duration: ☐ 3 months ☐ 6 months ☐ Long-term or until otherwise indicated
Indication(s): _____
(NOTE: Clinical Pharmacist will bridge when necessary per protocol unless otherwise indicated)

☐ **ANTICOAGULATION – Non-Vitamin K antagonist**
Agent(s): ☐ Injectable monotherapy: _____
Duration: ☐ 3 months ☐ 6 months ☐ Long-term or until otherwise indicated
☐ Direct Oral Anticoagulant: _____
Duration: ☐ 3 months ☐ 6 months ☐ Long-term or until otherwise indicated
Indication(s): _____

☐ **DIABETES**
HbA1c Goal: ☐ Less than 6.5% ☐ Less than 7% ☐ Other: _____ NOTE: Excludes insulin pumps

☐ **DYSLIPIDEMIA**
☐ Drug Therapy Management ☐ Other: _____

☐ **HYPERTENSION**
BP Goal: ☐ Less than 130/80 ☐ Less than 140/90 ☐ Less than 150/90 - elderly without renal disease or DM
☐ Other: _____

☐ **HEART FAILURE**
☐ Lifestyle/Medication Education Only ☐ Drug Therapy Management

☐ **COPD**
☐ Counseling + Inhaler Technique Only ☐ Drug Therapy Management

☐ **TOBACCO CESSATION**
☐ Counseling + OTC and prescription medications

☐ **WEIGHT MANAGEMENT**
☐ Drug Therapy Management ☐ Other: _____

COLLABORATIVE PRACTICE AGREEMENT EXCEPTIONS:
☐ Temporary referral (3 weeks only) ☐ Contact MD for all anticoag bridging ☐ Other: _____

Pertinent PMH: _____

☐ I, referring provider, attest that I have discussed this referral with the patient, and the patient has provided consent to the sharing of their demographic and contact information with Memorial Hermann or its affiliated providers for the purposes related to this referral, including: (1) telephone calls and text messages regarding health care, including but not limited to scheduling, reminders, and medication refills; (2) email or mail communications regarding health care, including but not limited to scheduling, reminders, and medication referrals; and (3) other information regarding my health care, billing and health related services and benefits. I have instructed the patient if they wish to revoke this consent, they may contact Memorial Hermann at 713-222-CARE (2273) or opt out directly after receipt of communication.

Provider Signature	Print Name	NPI/MHHS ID.	Date	Time ☐ AM ☐ PM	Contact No.

Fax referral. Patients are contacted by clinic for follow-up. Outpatient referrals: Fax clinic note/recent labs. If appointment is required immediately, page after faxing referral. **(Pharmacists are authorized to sign prescriptions for medication initiation, titration, and/or maintenance per collaborative practice agreement (CPA). Disease state, medication, lifestyle, and dietary education provided. Limited physical exam and point-of-care testing per CPA)**

☐ Southeast, Fax: (713) 704-0585, Phone: (281) 929-4227 ☐ Southwest, Fax: (713) 704-3855, Phone: (713) 456-4166
☐ TIRR, Fax: (713) 797-5788, Phone: (713) 797-5251 ☐ TMC – CAHF, Fax: (713) 704-0114, Phone: (713) 704-5042
☐ TMC, Fax: (713) 704-0993 , Phone: (713) 704-2626, Page (713) 605-8989 x 20982

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