

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.

AM

PM

Provider Signature **Print Name** **NPI/MHHS ID.** **Date** **Time** **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

**MEMORIAL
HERMANN**

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**Changes
submitted
before
6-5-24**