Physician to Complete Date of Referral: ____________________

Patient Name: ____ DOB: ____________________________

Patient's Home Phone Number: _____________________________ Alternate Number: _______________________

Address:____

Referring MD: ______________________________ Referring MD Phone Number:

Referring MD Office Fax Number: ____________________________________

PLEASE ATTACH MOST RECENT HISTORY AND PHYSICAL AND LABORATORY DATA IF THAT INFORMATION IS NOT AVAILABLE IN THE EVERGREENHEALTH CERNER COMPUTER SYSTEM.

PLEASE COMPLETE THE FOLLOWING INFORMATION

1. Diagnosis/indications for HYPERTENSION MANAGEMENT referral (**required**):

   ____

2. Complicating Factors (current or history of):
   (For referrals from outside of the EvergreenHealth Cerner or Centricity EMR, please provide a recent H&P)

   ____

3. Activity Restrictions:

   ____

4. Visit frequency:
   - ✓ Every 1 -4 weeks or per pharmacist determination
   - ☐ Other: ____

5. Anticipated Referral Duration:
   - ☐ Manage until at goal x3 visits
   - ☐ Manage indefinitely
   - ☐ Consult x1

___________________________________ ____________ ____________

Physician/Advanced Practice Clinician Signature* **Date** **Time**

____

Printed Name

*Signature indicates provider's order for evaluation and management of above related conditions by EvergreenHealth Pharmacist Provider Services, assignment of benefits to EvergreenHealth and authorization for the use of Washington State Department of Health, Pharmacy Commission submitted collaborative therapy agreement. Ordered Frequency of Laboratory Tests and Evaluation/Monitoring Clinic Visits: Per treatment plan schedule.

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Pharmacist Provider Services Hypertension Management

Phone: (425) 899-2783 Fax: (425) 899-2784 Please fax completed referral forms

Kirkland, WA 98034

HYPERTENSION MANAGEMENT – PHARMACIST PROVIDER SERVICE REFERRAL AND PATIENT SPECIFIC TREATMENT PLAN

FORM ID RX 520
Approved 10/19

APPLY PATIENT LABEL HERE

Original – External clinic chart Fax/copy – EvergreenHealth Medical Record

MR