



Community Pharmacy Service Referral Form

The Hong Kong Pharmaceutical Care Foundation is an NGO devoted to providing pharmaceutical service improving medication use in community by using our pharmacists' professional knowledge. It is our pleasure to work with other health care professionals and provide assistance. For details about our organization, please visit our website www.pcfhk.org. For questions, please contact our pharmacist Ms. Grace Tang at 3708 8551.

Please print or complete electronically and fax to 3708 8553:

Referrer Information		
Date:	/ /	
Referring from (organization):	_____	
Name of nurse:	_____	
Contact number:	_____ Email: _____	
Reason(s) for referral (You may check more than 1 box):		
<input type="checkbox"/> Patient counselling on drug	<input type="checkbox"/> Home visit	<input type="checkbox"/> Dispense self-financed item (SFI)
<input type="checkbox"/> Drug Subsidy Program	<input type="checkbox"/> Pill box management	<input type="checkbox"/> Drug compliance advice
<input type="checkbox"/> Other:	_____	

Patient Condition		
Patient Name: _____	Age: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Contact person: <input type="checkbox"/> Patient himself/herself	<input type="checkbox"/> Other: _____	
Contact number: _____		
Diagnosis:		
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Dyslipidemia	<input type="checkbox"/> Diabetes mellitus
<input type="checkbox"/> Heart failure	<input type="checkbox"/> Cardiac arrhythmia	
<input type="checkbox"/> Other:	_____	
Allergies:		
<input type="checkbox"/> Yes (Please specify): _____		
<input type="checkbox"/> NKDA (No Known Drug Allergy)		
Has the patient registered with the electronic health record sharing system (eHRSS)?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	