UMC Health System

PHARMACY CLINIC REFERRAL PLAN

Patient Label Here

PHYSICIAN ORDERS

Diagnosis _____

Weight _____ **Allergies** _____

Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.

ORDER	ORDER DETAILS
	Medications
	Medication sentences are per dose. You will need to calculate a total daily dose if needed.
	Select from the following protocols to guide pharmacists. Multiple protocols may be selected. **General Medication Therapy per Pharmacy (General Medication Therapy per Pharmacy Clinic)** ☐ ONE TIME, Start date T;N ***Reference Text***
	VTE Anticoagulation Therapy per Pharmacy (VTE Anticoagulation Therapy per Pharmacy Clinic) ☐ ONE TIME, Start date T;N ***Reference Text***

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ **Date** _____ **Time** _____