MEDICATION MANAGEMENT SOLUTIONS

Client Referral Form

medex PHARMACIST GROUP

Referrer contact details:

Name	
Company Name	
Company Address	
State/Territory	
Email	
Telephone	
Date Submitted	

Client details (claimant/employee):

Surname	
First name	
Title	
Date of birth	
Address	
State/Territory	
Claim Number	
Date of Injury	
Injury Description	
Client Contact Details	Email:
	Mobile:
	Do we have permission to contact the Client: ☐ Yes ☐ No
Treating Doctor Name	
Treating Doctor Contact Details	Email:
	Telephone:
	Do we have permission to contact the Treating Doctor: ☐ Yes ☐ No

Service requested:

- ☐ MediRisk (Risk identification report)
- ☐ Pharmacy Review
- ☐ File Review
- ☐ Medication Cost Analysis Report

Please provide the details of your referral and any specific questions:

Additional Information (If relevant):

Please provide the following documents with your referral and send to us via the email address below:

- Signed medical certificate of capacity (required for all referrals)
- Independent medical reports (if available)
- Reports from treatment providers
- Medication invoices
- Any other documentation which may assist