Milton Keynes Clinical Commissioning Group

MEDICINES OPTIMISATION REFERRAL FORM

Patient Information

GP Name and Surgery: _____

Pt.Name: _____
D.O.B.: _____
NHS No: _____
Address: _____
_____
Contact Phone No: _____

Reason for Referral

Prescribing issues ☐
Compliance issues ☐
Device counselling ☐
Medication review ☐
Waste issues ☐

Other – please specify: _____
_____

Relevant medical history: _____

Risks identified for referral (please give a brief summary): _____
_____
We may need to contact you for more information prior to the visit.

Any other relevant information or risks: _____

Recent hospital admission Yes/No* Date:

Patient aware of referral: Yes/No*
Referral requested by: ……
Job Title: ……

Contact details: ……

For office use only:
Date of visit arranged: …… Date of Visit:……
Feedback to: Practice*/Community Practice* Yes/No* (**delete as appropriate*)

August 2016

For MMT use only

Notes:

Issues for Review:

Actions Required:	Date: