[](http://www.celebrationhealth.com/)

**Clinical Pharmacy Services**

400 Celebration Place, Ste A110, Celebration, FL 34747

Phone: 407-303-4639 • Fax: 407-303-4519

[www.floridahospital.com/celebration-health/general-health/clinical-pharmacy-services/coumadin-clinic](http://www.floridahospital.com/celebration-health/general-health/clinical-pharmacy-services/coumadin-clinic)

Fax

|  |  |  |  |
| --- | --- | --- | --- |
| **To:** | Dr. | **From:** | Medication Management Clinic at Celebration Health |
| **Fax:** |  | **Pages:** | 2 including cover sheet |
| **Phone:** |  | **Date:** |  |
| **Re:** | MM Enrollment | **Pt:** | (DOB:) |

🞎 Urgent 🞎 For Review 🞎 Please Comment **🗹** Please Reply 🞎 Please Recycle

Dear Doctor:

Your patient  dob:was recently hospitalized at Florida Hospital. Celebration Health recommends following up with the Medication Management Clinic for up to 30 days post-discharge for recently hospitalized patients. The goal of this clinic is to **optimize medication use, improve medication safety and facilitate physician follow-up** as the patient transitions from the hospital to outpatient care. The initial visit with our pharmacist-led service is typically an hour to assure a thorough medication history is obtained and assessed as well as extensive patient education provided. You will receive a faxed summary of each patient visit to the clinic.

Attached is the Medication Management Clinic enrollment form. Please **complete and fax the one-page enrollment form** to 407-303-4519. We recognize there are many factors taken into consideration when medical decisions are made, many of which may be unavailable to us. We have encouraged the patient to schedule a follow-up appointment with you to discuss their medications and recent hospital stay. Please feel free to contact us with any questions or concerns at 407-303-4639. Thank you for allowing us to participate in this patient’s care.

Thank you,

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**Medication Management Clinic Enrollment Form**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient Information** | | | | |
| Patient name: | | | DOB: | |
| Insurance information: | | | Phone: | |
| **Referring Physician Information** | | | | |
| Physician printed name: | | | NPI: | |
| Physician Phone: | | | Physician Fax: | |
| **Reason for Referral:** | | | | |
| **Recent Hospital Stay**: | | Discharge Date (if known): | |  |
| Primary Diagnosis: | |  |
| **Complex Medication Regimen:** | | Explain: | | |
| **Medication Education:** | | Explain: | | |
| **Pre/Post-Surgery Med Reconciliation:** | | Explain: | | |
| **Smoking Cessation Follow-up:**  (must provide primary diagnosis) | | Primary Diagnosis: | |  |
| **Other:** | | Explain: | | |
| **Specific Goals or Specific Areas of Concern (optional):** | | | | |
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| **Anticipated Duration of Therapy:** | | | | |
| Patients will be followed by MM for at least 30 days post-discharge, or as appropriate. | | | | |
| **Initial Enrollment** | | | | |
| Patients will be followed by the Medication Management Clinic for at least 30 days after a hospital discharge or as appropriate to facilitate a safe transition between patient care settings or levels of care. This provides an opportunity for patients to discuss their medications, lab work, and follow-up appointments and have any remaining questions answered. The below signature indicates agreement to MM policies and procedures (available upon request). | | | | |
| **Physician’s signature** (required) | **Date** | | **Comments** | |
|  |  | |  | |

\*Attach any supporting documentation that maybe helpful in processing this enrollment and facilitating patient care**.**

**Please note:** The current prescriber is responsible for the management of the patient’s therapy until he/she is seen in the MM Clinic.