Oregon CAREAssist MTM Program Referral Form
Please fax back to 510-587-2729
Attn: Eunice Ndzerem, Pharm.D, MPH

Date of referral: _____

Referral Source Name (Please print): _____

Referral Source Title (i.e., case manager, prescriber, etc.): _____

Referral Source Agency Name: _____

Referral Source Phone Number: _____

Referral Source Fax Number: _____

Referral Source email address: _____

Patient Information (Please print)

Patient Name: _____

Date of Birth: _____ OR CAREAssist ID # (if known): _____

Prescriber Name: _____

Prescriber Phone # / Fax #: _____

Referral Reasons

- ☐ Detectable viral load
- ☐ Medication non-adherence
- ☐ Other
- ☐ General pharmacist follow-up
- ☐ General disease state education

Specific Issues that you would like to see addressed or any notes on the patient:

_____

_____

_____

_____

Please feel free to use multiple pages if necessary.