

[Your Name, PharmD, BCPS/BCACP]
[Clinical Pharmacist Title]
[Clinic/Institution Name]
[Phone Number]
[Email Address]

[Date]

[Recipient Name, MD/DO/NP/PA]
[Specialty/Department]
[Facility Name]
[Address]

**RE: CLINICAL PHARMACY REFERRAL FOR [PATIENT NAME] (DOB:
[MM/DD/YYYY])**

Dear [Recipient Name],

I am writing to formally refer [Patient Name] for comprehensive ambulatory care pharmacy services and medication therapy management (MTM) regarding the following clinical indication(s):

- [e.g., Chronic Disease State Management: Diabetes, Hypertension, Anticoagulation]
- [e.g., Polypharmacy Review and Medication Reconciliation]
- [e.g., Medication Adherence Support and Education]
- [e.g., Cost-Effective Therapy Transitions]

Clinical Background:

[Brief summary of patient's current status, relevant lab values (e.g., A1c, BP, INR), and specific challenges or goals for this referral.]

Requested Pharmacist Intervention:

Under our existing Collaborative Practice Agreement (CPA), I will proceed with:

- Comprehensive medication review and reconciliation.
- Dose titration and optimization based on evidence-based guidelines.
- Patient counseling on administration, side effects, and therapeutic lifestyle changes.
- Ordering of necessary laboratory monitoring related to drug therapy.

I will provide a detailed clinical note following each encounter and will contact your office directly should any urgent therapeutic adjustments or contraindications arise.

Please contact me at [Phone/Extension] if you have specific clinical priorities or questions regarding this referral.

Sincerely,

[Your Name, PharmD]
Ambulatory Care Pharmacist