Date: [Date]

From: [Pharmacist Name, Credentials]
Facility: [Department/Institution]
Contact: [Phone/Email]

RE: Patient Referral for Oncology Pharmacy Services

Patient Name: [Full Name]
DOB: [Date of Birth]
Diagnosis/Stage: [ICD-10 Code / Clinical Diagnosis]

Dear [Recipient Name/Provider],

I am referring the above-mentioned patient for comprehensive oncology pharmacy management. The patient is currently scheduled to initiate [Treatment Regimen Name] on [Start Date].

Requested Services:

- Medication Therapy Management (MTM) and polypharmacy review.
- Chemotherapy/Immunotherapy education and toxicity counseling.
- Dose adjustment recommendations based on renal/hepatic function.
- Oral Oncolytic adherence monitoring and side-effect management.
- Financial toxicity assessment and co-pay assistance coordination.

Current Clinical Status & Concerns:
[Brief summary of comorbidities, allergies, or specific medication concerns]

Please find the attached medication list and recent laboratory results. I am available for further consultation regarding this patient's pharmacological care plan.

Sincerely,

____
[Signature]
[Name and Title]