



MedicationXpert.com Senior Care Services Referral Request Form

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

Physician Phone: \_\_\_\_\_

Physician Fax: \_\_\_\_\_

Please check one:

- I request the Senior Care Pharmacist review the medications for the above-named patient and submit his/her Drug Therapy Management Recommendations to me for final approval.
  
- I do not wish the Senior Care Pharmacist to review the medications for the above-named patient and offer his/her Drug Therapy Management Recommendations to me for my approval or disapproval.

Primary Physician Signature: \_\_\_\_\_

Please fax this form to 770-412-8755 or return to patient or patient representative for presentation to MedicationXpert, LLC.

Thank you.

A handwritten signature in black ink that reads "Armon B. Neel, Jr., PharmD".

Armon B. Neel, Jr., PharmD, CGP, FASCP  
Senior Care Consultant