



SVdP Georgia Community Pharmacy Referral Data Collection

Below is the information you will need to collect from the neighbor in need so that you can submit an online referral to the Community Pharmacy. Please gather all of this information PRIOR to submitting your referral application, as incomplete applications will cause a delay in the process.

CLIENT INFORMATION

Name _____

Gender Male Female Other

Address _____

City/State/Zip _____

County _____

Home Phone _____ Cell Phone _____

Client Email _____

Date of Birth _____

Age _____

Ethnicity Native American Asian African American/Black Caucasian/White Hispanic/Latino Other

Family Household Information Adult with dependent children Adult w/out dependent children Veteran Homeless

Is the client undocumented?
Yes No

Is the client uninsured?
Yes No

Is the client underinsured?*(Does the client have insurance coverage but the limits may not be high enough to cover the full expense of medications?)

Yes No

PRESCRIPTION ASSISTANCE ELIGIBILITY

Does the client
have a primary
care physician? Yes No

If yes, please provide:

Physician
Name

Clinic

Phone Number

Fax Number

PRESCRIPTION INFORMATION

Please list all prescriptions that the patient needs below. Be sure to include ALL of the information requested as incomplete information will cause a delay in processing the referral and/or prescription transfer.

Encounter (N/T/R/E)	Drug Name & Strength	Prescription #	Pharmacy Name	Pharmacy Phone

Please list any/all Allergies: