TITLE: **MOUNT CARMEL PHARMACY OUTPATIENT CARE CENTER REFERRAL ORDER FOR SMOKING CESSATION MANAGEMENT**

NOTE: ☑ THESE ORDERS CAN BE CHECKED BY THE PHYSICIAN TO DESIGNATE FURTHER INSTRUCTIONS. THESE ORDERS WILL BE FOLLOWED UNLESS CROSSED OUT.

DO NOT USE THE FOLLOWING ABBREVIATIONS: U or u; Q.D., QD, q.d., qd; Q.O.D. QOD, qod, q.o.d., IU, MS or MSO4 or MgSO4; trailing zero; lack of leading zero

1. ☑ By this referral, I understand that my patient will have their smoking cessation managed by the pharmacist of the Mount Carmel Pharmacy Outpatient Care Center according to established policies and procedures. I will resume care if required by established policies and procedures. In addition, I grant prescriptive authority for these agents under my name, authorize the pharmacist to order smoking cessation medications according to the protocols when needed, and allow the clinic to act as an agent to initiate and execute the insurance prior authorization process. I concur with these guidelines and permit their implementation in this patient. I consider this program to be a necessary part of the patient's medical care.

PLEASE PRINT THE FOLLOWING INFORMATION:

Patient name _____ Phone _____

Date of birth _____ Last 4 numbers of Social Security _____

Insurance_____

Diagnosis/ICD-10_____

Please send the last Office Note, Past Medical History, and Current Medication List

Physician (please print)_____ Phone _____

Fax _____

Please fax this form to the appropriate Pharmacy Outpatient Care Center:

☐ Mount Carmel East	☐ Mount Carmel St. Ann's	☐ Mount Carmel Grove City
614-234-8844 phone	380-898-6020 phone	614-663-4995 phone
614-234-8850 fax	380-898-6021 fax	614-663-4994 fax

Physician Signature _____ Date _____ Time _____

NAME

DOB

MR #

FIN #