MedsCheck
Paladdin Health Group

Tel: 877-686-5493
Fax: 877-263-3706
referrals@paladdinhealth.com

Referral Date: _____

Referred by: _____

Phone: _____ eMail: _____

Client Name: _____ DOB: _____

Client Telephone _____ Female ◉ Male ○

Health Card Number: _____ Version Code: _____

| **Ontario MedsCheck at Home Program Eligibility** | **Yes** |
|---|---|
| • Are you taking 3 or more medications to manage chronic disease? | ☐ |
| • Are you *unable* to attend your Community Pharmacy? | ☐ |
| • Has it been more than 12 months since your last MedsCheck? | ☐ |
| • Optional: Are you diabetic? | ☐ |

| **Consent to Share Information** | **Yes** |
|---|---|
| I agree to share my personal information for the purpose of providing a **MedsCheck At Home**. | ☐ |
| Contact Paladdin Health to arrange a **MedsCheck at Home**. | ☐ |
| **[OR]** Contact my Pharmacy to arrange a MedsCheck | ☐ |

**Signature:** _____ Client or POA or SDM **Date:** _____

Power of Attorney (POA) Name: _____ Tel: _____

Substitute Decision Maker (SDM) Name: _____ Tel: _____

Notes: _____

| **MedsCheck At Home. Appointment Request:** | |
|---|---|
| Day: Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ | Time: am ☐ pm ☐ eve ☐ |
| Street: | Buzzer Code: |
| City: | Postal Code: |
| Building/Apt #: | |
| Client Caregiver Name: | |
| Caregiver Phone: | |
| Client Pharmacy Name: | |
| Pharmacy Location: | |
| Pharmacy Tel: | Pharmacy Fax: |