



Community Care
of North Carolina

Community Care of Wake/Johnston Counties

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Provider Referral Form for Clinical Pharmacist

Today's Date: _____	Practice: _____
Patient Name: _____	Referring Provider: _____
Date of Birth: _____	Medicaid #: _____
Date of Patients Next Appointment: _____	

Reason for Referral:

- Patient on 8 or more medications
- Generic equivalent or PAL substitution possible
- Poly Providers/Practices
- PCP request PharmD assistance with MTM review
- Potential Drug – Drug Interaction
- Possible medication duplication
- Other

Please explain: _____

PLEASE FAX COMPLETED FORM TO CHERYL VIRACOLA, PHARMD @ 919-250-9614