



Good Value Pharmacy

Patient Adherence and Competency of Therapy (PACT) Referral Form

Phone: 262-925-0201 Fax: 262-925-8373

Please fax this form to the number above and we'll set the patient up on our compliance packaging and home delivery program. We will complete a comprehensive medication review and coordinate with the patient and their doctors to ensure accuracy of the medication regimen.

Patient's Name _____ Date of Birth _____

Address _____ City _____ Zip _____

Phone Number _____ Male Female

Referral Source (you) _____ Referral Source Phone _____

Optional fields (we can obtain this information from the patient if you do not complete):

Primary Doctor _____ Specialists _____

Current Pharmacy _____

Last 4 of SSN _____ Insurance: Medicare Medicaid Commercial

Caregiver Name _____ Caregiver Phone _____

If available, please fax current med list along with this form