Transitions of Care Pharmacist Referral Form

Please send completed form to PharmacyLiaison@ucare.org

(available for members in these plans) ☐ MSHO (Minnesota Senior Health Options) ☐ Connect + Medicare

Patient Information

Member Name:	Date of Birth:	UCare ID#:
Member speaks: ☐ English ☐ Burmese ☐ Hmong ☐ Karen ☐ Spanish ☐ Somali ☐ Russian ☐ Other: _____		Phone:

Discharge Information

Name of Hospital:	Date of Discharge:

Referral Source

Name and relationship of person referring:	Email:
Phone:	

Please describe reason for referral:

****Please include a copy of the discharge summary if available****

*Attach discharge summary and any other supporting documentation that maybe helpful in processing this referral.