CELEBRATION HEALTH
FLORIDA HOSPITAL
Clinical Pharmacy Services
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www.celebrationhealth.com/clinical-pharmacy-services

Transition Clinic Enrollment Form

Patient Information	
Patient name: _____	DOB: _____
Insurance information: _____	Phone: _____

Referring Physician Information	
Physician printed name: _____	NPI: _____
Physician Phone: _____	Physician Fax: _____

Reason for Referral:		
☐ **Recent Hospital Stay**:	Discharge Date (if known):	_____
	Primary Diagnosis:	_____
☐ **Complex Medication Regimen:**	Explain: _____	
☐ **Medication Education:**	Explain: _____	
☐ **Pre/Post-Surgery Med Reconciliation:**	Explain: _____	
☐ **Smoking Cessation Follow-up:** (must provide primary diagnosis)	Primary Diagnosis:	_____
☐ **Other:**	Explain: _____	

Specific Goals or Specific Areas of Concern (optional):

Anticipated Duration of Therapy:
Patients will be followed by TOC for at least 30 days post-discharge, or as appropriate.

Initial Enrollment
Patients will be followed by the Transition Clinic for at least 30 days after a hospital discharge or as appropriate to facilitate a safe transition between patient care settings or levels of care. This provides an opportunity for patients to discuss their medications, lab work, and follow-up appointments and have any remaining questions answered. The below signature indicates agreement to TC policies and procedures (available upon request).

Physician's signature (required)	**Date**	**Comments**
1. ⇨		

*Attach any supporting documentation that maybe helpful in processing this enrollment and facilitating patient care**.**
Please note: The current prescriber is responsible for the management of the patient's therapy until he/she is seen in the TC Clinic.