Pharmacare
Centric Health

-Updated March 24, 2017

PHARMACY ADMISSION FORM

PERSONAL INFORMATION

First Name:_____ Middle Initial:_____ Surname:_____

Date of Birth:_____ ☐ Male ☐ Female Personal Healthcare #: _____

Address_____ Postal Code: _____

Resident Phone Number:_____ Cellphone Number: _____

Drug insurance Type: _____ ID #:_____ Group #:_____

Diagnosis:_____ Allergies:_____

Previous Pharmacy: _____

Family Doctor: _____ Phone: _____ Fax: _____

Specialist: _____ Phone: _____ Fax: _____

Do you pay your own bills? ☐ Yes ☐ No

If NO, please indicate: _____ (Name) _____ (Relationship) _____ (Phone: home/business)

Emergency Contact: _____ (Name) _____ (Relationship) _____ (Phone: home/business)

Are you on a medication assistance program through the community?

If Yes ☐ Homecare ☐ Other (specify):_____

Independent – do you take your own medications? ☐ Yes ☐ No

If independent client (no medication assistance), please check the type of packaging you prefer:
☐ Blister ☐ Tear-able ☐ Dosette ☐ Reg Vials ☐ Child Proof ☐ 3 Months' Supply

Comments:

HEALTH COVERAGE

Type of Plan	Card Number	Single/Family
Alberta Blue Cross		
2nd Blue Cross Plan		
Social Services		
Other: DVA/AISH, etc.		

Please fax the **completed form and consent form** to Pharmacare || FAX: 780-444-9305|| TOLL FREE FAX: 1-855-944-9305

Pharmacare Fulfillment Centre 17969-106 Ave
Edmonton, AB T5S 2H1

Toll Free Ph#: 1-855-944-3257
Toll Free Fax#: 1-855-944-9305

Pharmacare
Pharmacy Services
a division of Centric Health

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PHARMACARE SERVICES CONSENT FORM

Name of Client:_____ ☐ M ☐ F **D/O/B:**_____

Phone:_____ **Name of Site/Program/Clinic:** _____

Please read the following terms and conditions:

- For the remainder of the consent, the word "I" or "my" will be used and will be interchangeable with "Substitute Decision Maker" and his/her consent where a substitute decision maker is in place.
- I agree to utilize the services of Pharmacare Pharmacy for medications and related products and consent to their Clinical Pharmacist consultative services.
- Clinical Pharmacist services include but are not limited to: Annual Care Plans (Standard Medication Management Assessment, Comprehensive Annual Care Plan) and Follow-ups, Therapeutic Drug Substitution and/or Dose Adjustment for Organ Function, Renewal of Prescription, Injection Services, Prescribing at Initial Access, Managing Ongoing Therapy, Emergency Prescribing, Trial Prescriptions and Refusal to Fill a Prescription due to Overdose Risk, Abuse or Fraudulent Purposes as per the Alberta College of Pharmacists Standards of Practice.
- I understand the pharmacist will conduct an assessment for the purposes of completing an annual pharmacy care plan and/or medication assessment, in accordance with the requirements set out in the Alberta Health Compensation Plan for Pharmacy Services.
- Annual care plans require the pharmacist to conduct medication reviews one-on-one. If I am not available I consent to have a licensed health care professional act as a witness at that time. I will be able to follow up with the pharmacist if I have questions regarding their findings.
- I understand that copies of annual care plans and medication assessments will be provided to me, as well as placed in the patient care file/chart as appropriate and will be available to me at any time by contacting the pharmacy.
- I understand that all medications and related products will be obtained by the preferred pharmacy and if other medications are purchased elsewhere they will not be repackaged as per Alberta College of Pharmacists Regulations.
- I understand that a Pharmacare prescribing pharmacist may prescribe and/or dose Tamiflu, in alignment with site policy and at no additional cost, for prophylaxis or treatmentin the event of a declared public health influenza A outbreak.
- I agree to pay all charges incurred that are not paid for by a third party payor, including Blue Cross, within the 30 day term.
- I understand that medications are by law not refundable or returnable under any circumstance and as such cannot be returned for credit.
- I understand that certain home health care products cannot be returned for refund due to health and safety standards.
- I understand that the pharmacist is actively involved in the care of the resident and will access, request or disclose health information for the purpose of providing care to the resident.
- I understand that (where applicable) the pharmacist may round with physicians or other prescribers in my room and is actively involved in the multidisciplinary team of healthcare professionals.
- I consent to the release of personal and medical information to any third party payor, government agency providing benefits, or other person(s)/entity liable for my treatment charges.
- I consent to a similar release of information, as shall be necessary, to initiate and continue pharmacy care or laboratory care.
- I consent to have my picture on the blister pack for easy identification purposes, where dispill blister packs are used, eMAR software or other medication packaging and administration tools for easy identification purposes.

Declaration & Consent of Client and/or Substitute Decision Maker (As Applicable): When a CACP / SMMA is prepared by the clinical pharmacist, I will review and discuss the CACP / SMMA with the clinical pharmacist who prepared it. I understand and accept that the goals and potential risks of the medication therapy outlined at the time the CACP / SMMA is completed and will be reviewed with me. I will be provided or can request a copy of the CACP / SMMA.

Date: _____

Client Name: _____ **Client Signature:** _____

Substitute Decision Maker (if applicable): _____ **Substitute Decision Maker Signature:** _____

Cellular Ph#: _____ **Work Ph#:** _____

Email: _____

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Pharmacy Services of Centric Health

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PHARMACARE FINANCIAL GROUP: CLIENT BILLING INFORMATION FORM

Internal Use Only

Resident Name: _____ **Community:** _____

Billing information: Please enter the information for person who is responsible to make payments for your account; if it is yourself, please put "SELF" for name.

Name: _____ **Relationship to Client:** _____

Daytime Phone: _____ **Home Phone:** _____

Billing Address: _____

City: _____ **Province:** _____ **Postal Code:** _____

Email: _____ **Fax:** _____

Method of Payment

Our terms are net 21 days and if any special term is required, you will have to arrange them with our Accounts Specialists. For your convenience, we offer the following payment options:

1. Pre-authorized debit payment
2. Pre-authorized credit card payment
3. Cheque/Cash net 21 days
4. Payment by telephone please call 780-444-3257 ext.3 or call our **toll free: 1-855-944-3257 ext.3**

☐ Pre-authorized Bank Account Debit **(copy of void cheque required)**

Bank Account #: _____

Branch #: _____ (up to 5 digits) Institution: _____ (3 digits) ☐ Pre-authorized Credit Card (Visa, MasterCard, and American Express)

Credit Card #: _____

Expiry (MM/YY): _____ Security #: _____ (3 digits on back or 4 digits on front for AMEX)

Name on Credit Card: _____

I/we authorize my/our financial institution to debit my/our account on (or after) the withdrawal date of each invoice for all amount owing to Pharmacare Financial Group. This authorization is valid for either the bank account or the credit card account specified above, or any other account which I/we may designate in the future in lieu of the account specified above. I/we understand that in the event that a payment is returned by the bank for any reason, that I/we will be responsible for NSF and/or $25 administration charges.*

I/we have certain recourse rights if any debit does not comply with this agreement. I/we have the right to receive reimbursement for any debit that is not authorized or is not consistent with this pre-authorized agreement. I/we may cancel this agreement at any time by providing written notice to the address below by contacting Pharmacare Financial Group at 780-444-3257 or call our toll free number 1-855-944-3257 (ext. 3) at least (15) fifteen days before the next scheduled withdrawal date. (the withdrawal date is currently on (or after) the 29th of every month)*

Client Signature: _____ Date: _____

*Please **fax with a void cheque** to Pharmacare Financial Group: Fax: 780-784-2844 **Toll Free Fax 1-855-944-6364***
Mail: PO Box 25503, Edmonton, AB T5T 7E7 || Email: billings@mypharmacare.ca