Patient Name_____ Date _____

Pharmacist Referral and Visit Summary

Today you were prescribed the following hormonal contraception: _____
(Notes: _____)

If you have a question, my name is _____

or –

____I am not able to prescribe hormonal contraception to you today, because:

□ Pregnancy cannot be ruled out. *(Notes: _____)*

□ You have a health condition than requires further evaluation. *(Notes: _____)*

□ You take medication(s) or supplements that may interfere with hormonal contraception. *(Notes: _____)*

Your blood pressure reading is higher than 140/90. *(___/___)*

Please review this information with your primary care or gynecologic care health provider.

For further information about safe and effective, long-acting reversible contraception (IUD/implants) visit www.bedsider.org

Pharmacist Name_____
Pharmacy Name_____
Address_____
Phone_____

***Attention Pharmacy**: This is a template document. Please feel free to customize it to your particular company, however you **must retain all elements** set forth by this template.*