IEHP Medication Therapy Management (MTM) - Referral Form

IEHP® A Public Entity
Inland Empire Health Plan

Refer your IEHP patients to the MTM program if they meet any of the criteria below *(Check all that apply)*:

- ☐ Taking four or more chronic medications
- ☐ Taking one or more medications related to severe Autism Spectrum Disorder (ASD) symptoms
- ☐ Observed non-compliance
- ☐ Special drug preparation needed
- ☐ Observed adverse effects

Please provide information below:

Patient's Name _____ Guardian Name _____ DOB _____

Address _____ City _____ State _____ Phone _____

Medical History (Include details if patient has experienced seizure events or other developmental conditions):

Name any current Autistic Programs the patient is enrolled in:

Special Diet/Nutrition:

Current Medications (Include strength and directions):

Previous Medications (Include strength and directions):

Reasons for Referral:

Known Allergies _____

Height (inches) _____

Weight (lbs) _____

BMI (kg/m2) _____

Gender? ☐ M ☐ F

Does patient smoke? ☐ Yes ☐ No

Is patient pregnant? ☐ Yes ☐ No

History of substance abuse? ☐ Yes ☐ No

Does patient drink alcohol? ☐ Yes ☐ No

Immunizations up to date?

☐ Yes ☐ No (If No, which were not given?) _____

Referred by _____ Phone _____

Signature _____ Date _____

Fax completed form to (909) 890-5763. For questions, call (909) 890-2054.

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