

**Referral Form for Well-Child Visit**

# Patient Name (First/Last):

Date of Birth: \_/ \_/

Referring Pharmacist: email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Practice: Phone Number:

FAX Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:

Date of Referral:

Signature: Date:

The above patient was seen in our pharmacy/practice today and the following vaccines administered. The patient was informed regarding the importance of well-child visits. Additional items needing potential follow-up are indicated below. Feel free to contact us if you have further questions. We would appreciate receiving an update after you have seen the patient so that our records are current and we can support your treatment plan. We have submitted the vaccines we gave today to the state/local immunization information system (IIS).

**Reason for Referral: 🞏 Well-child checkup 🞏 Other follow-up**

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| --- | --- |
| **The following vaccine(s) were administered today:**   * DTaP * Hep A * Hep B * Hib * HPV * Influenza * MMR * Meningococcal * Pneumococcal (PCV) * [Polio (IPV)](https://kidshealth.org/en/parents/polio-vaccine.html) * [Rotavirus](https://kidshealth.org/en/parents/rotavirus-vaccine.html) * Td / Tdap * Varicella * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Patient may need additional immunization(s)**        **Comment:** |
| * **Comments / Observations:** | |