# SVdP Georgia Community Pharmacy Referral Data Collection

Below is the information you will need to collect from the neighbor in need so that you can submit an online referral to the Community Pharmacy. Please gather all of this information PRIOR to submitting your referral application, as incomplete applications will cause a delay in the process.

**CLIENT INFORMATION**

Name* _____

Gender Male Female Other

Address _____

City/State/Zip _____

County* _____

Home Phone* _____ Cell Phone _____

Client Email* _____

Date of Birth _____

Age _____

Ethnicity Native American Asian African American/Black Caucasian/White Hispanic/Latino Other

Family Household Information Adult with dependent children Adult w/out dependent children Veteran Homeless

Is the client undocumented?*
Yes No

Is the client uninsured?*
Yes No

Is the client underinsured?* *(Does the client have insurance coverage but the limits may not be high enough to cover the full expense of medications?)*

Yes No

**PRESCRIPTION ASSISTANCE ELIGIBILITY**

Does the client have a primary care physician? Yes No

*If yes, please provide:*

Physician Name _____

Clinic Phone Number _____

Fax Number _____

**PRESCRIPTION INFORMATION**

Please list all prescriptions that the patient needs. Be sure to include ALL of the information requested as incomplete information will cause a delay in processing the referral and/or prescription transfer.

| Drug Name & Strength | Prescription # | Pharmacy Name | Pharmacy Phone |
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**Please list any/all Allergies:**