Tennessee Pharmacist-Provided Hormonal Contraceptives Referral and Visit Summary

Patient Name_____Date_____

☐ **I have provided you with the following hormonal contraception today: _____**

Notes:

_____

In addition, I have discussed and provided information to you on the following:

☐ Risk assessment for hormonal contraception

☐ Standard factsheet about hormonal contraception

☐ Information about the specific contraceptive option you are taking home today

☐ Contact information for a local women's health care provider (see below)

—or—

☐ **I am not able to provide hormonal contraception to you today because:**

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

☐ You have a health condition that requires further evaluation. *(Notes: _____)*

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

☐ Your blood pressure reading is higher than 140/90. *(Today's blood pressure reading: _____/_____)*

The box(es) checked above require further evaluation by a local primary care or women's health care provider prior to you receiving hormonal contraception.

Pharmacist Name_____

Pharmacy Name_____

Pharmacy Address_____

Pharmacy Phone_____

Please review this information with your primary care or women's health provider.

Contact information for follow-up from a local primary care or women's health care provider:

Provider/Clinic Name_____

Provider Address_____

Provider Phone_____

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