**全民健康保險提升用藥品質之藥事照護計畫**

附件四

**藥事照護計畫轉介單**

轉介日期： 年 月 日

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 轉介單位填寫欄 | 個案基本資料 | 個案姓名 | | |  | | | | | | | 性別 | | | | □男 □女 | | | | | | | 出生年月日 | | | | |  |
| 身分證字號 | | |  | | | | | | | | | | | 聯絡人 | | | |  | | | | | | 關係 | |  |
| 聯絡電話 | | |  | | | | | | | | | | | 住址 | | | |  | | | | | | | | |
| 轉  介  目  的 | * 1. 病人有用藥認知或用藥問題需專業協助。   1.1□請協助病人提升對藥品的認知或正確用藥。  1.2□病人有閱讀困難、語言困難、昏暈、失憶等認知狀況。  1.3□病人有不方便取藥、視力不好、聽力障礙等狀況。  1.4□其他：(請描述)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * 1. 病人因跨院所就診、甫出院或即將轉介至他院就醫，有以下相關用藥問題，需藥師協助輔導並回饋醫師   2.1□進行藥物交互作用、治療禁忌等評估。  2.2□協助整合用藥  2.3□追蹤病人療效/用藥反應  2.4□其他：(請描述)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  3. 其他情況：(請描述) | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 上述勾選特質相關的疾病/症狀及用藥等之簡述： | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 單位基本資料 | 健  保  署 | 單位名稱 | | |  | | | | | | | | | | | | | 聯絡窗口 | | | | | |  | | | |
| 聯絡電話 | | |  | | | | | | | E-mail | | | |  | | | | | | | | | | | |
| 醫  療  院  所 | 機構名稱 | | |  | | | | | | | | | | | | | 醫事機構代碼 | | | | | |  | | | |
| 轉介醫師 | 姓名 | | |  | | | | | | | 身份證字號 | | | | | \*為申報「醫師轉介費」所需資料，請務必提供 | | | | | | | | | |
| 聯絡電話 | | |  | | | | | | | E-Mail | | | | |  | | | | | | | | | |
| 聯絡窗口 | 姓名 | | |  | | | | | | | 聯絡電話 | | | | |  | | | | | | | | | |
| E-Mail | | |  | | | | | | | | | | | | | | | | | | | | | |
| 欲轉介  藥局名稱 | |  | | | | | | | 藥局  電話 |  | | | | | | | | | | 藥師  姓名 |  | | | | | | |
| □ 若無合作社區藥局，可逕提交予中華民國藥師公會全國聯合會協助媒合。  電話：02 -2595 -3856 分機 128 傳真：02 -2599 -1052 E-Mail：ftpa02@taiwan-pharma.org.tw | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 轉介人員/醫師簽章： | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 藥局回覆欄 | 處理 情形 |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 藥局名稱 |  | | | | | | 聯絡電話 |  | | | | | | 藥師姓名 | | |  | | | | | | 回覆日期 | | |  | |