COMMUNITY INTEREST FORM

Date: _____

Community Name: _____ AFH / ALF / IL / MC / SL / GL

Initial Contact: _____ Initial Contact phone/email: __(_____)_____

email: _____

Referral from: _____ Contact: _____

Pharmacy need:

- ❑ New Community – Open(ed): _____
- ❑ Transition needed: Current Pharmacy: _____ Packaging: _____MAR/eMAR: _____

Reason:

- ❑ Other: _____

Address: _____ # Beds: _____

Facility Phone: _____ Facility Fax: _____

Corporation: _____ Other Communities: _____

Website: _____ Fb /Insta / Linkedin: _____

Preferred Packaging: Strip pack / Synmed / Bubble Pack / Vial

Delivery cycle: Weekly / Bi-Weekly / 28 day Scheduled

C4/5's packaged: Separately / Cycle packs

PRN Packaging: 30-day bubble / 16 dose Opti- packs / Vial

MAR: Paper MAR / EMAR: _____

Current cycle and fill dates: _____

Projected Start Date: _____

Cart: Y or N #_____ -Specifics_____ Fax Machine: Y or N # _____

Continuing Education: _____ # of staff: _____

Portal Access: _____

DME: _____ Contact person: _____

Other details: