Bloom Enrollment Extension

Date (Y-M-D) _______________Bloom member #: _________—__________________

Name	Date enrolled (Y-M-D)
Extension request	☐ 6-12 months ☐ 12-18 months ☐ 18-24 months
Contact Preferences	Reviewed Y N Date reviewed (Y-M-D)

Summary of Problems and Outcomes

Problem	Actions taken	Outcomes[¶]				Notes
		Resolved	Improved	Unchanged	Worse	
		☐	☐	☐	☐	
		☐	☐	☐	☐	
		☐	☐	☐	☐	
		☐	☐	☐	☐	
		☐	☐	☐	☐	
		☐	☐	☐	☐	
		☐	☐	☐	☐	

[¶] Give priority to the patient's subjective assessment for rating each problem's outcome.

Extension Rationale

Describe the reason for 6 month extension. Include the planned actions and the reason they are expected to help the patient's recovery.

Rationale	**Planned actions**	**Reason to expect positive outcome in ≤ 6 months**

Patient signature: ____________________ Pharmacist signature: ______________________ Pharmacist Name: __________ Duration: _____

© 2014 Gardner D, Murphy A