PHARMACY INFORMATION FORM

DUE THE NEW PHARMACUTICAL LAWS YOUR PRESCRIPTION WILL BE SENT DIRECTLY TO YOUR PHARMACY. PLEASE FILL IN THE FOLLOWING INFORMATION SO THAT WE MAY DO SO ACCORDINGLY.

THANK YOU

PATIENT NAME: _____

PHARMACY NAME: _____

PHARMACY ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE: _____

PHARMACY TELEPHONE NUMBER: _____

DO YOU HAVE ANY KNOWN DRUG ALLERGIES? (CIRCLE ONE) YES NO UNKNOWN

IF YES, PLEASE LIST THE DRUG & THE REACTION:

ALLERGY	REACTION	DATE STARTED
_____	_____	_____
_____	_____	_____
_____	_____	_____