MEDICATION – PRESCRIPTION LIST

Name _____ DOB _____ Practice # _____

Phone # (___) _____

Pharmacy _____

Pharmacy Phone (___) _____

ALLERGY INFORMATION

_____

_____

_____

Date	Medication	Dose	Freq.	Quantity	Enter Authorized Refill dates and your Initials			

Please note: this example of a medication form that may benefit practices that do not routinely refill prescriptions. Be sure to identify the individual who calls in the refill.