MEDICATION – PRESCRIPTION RECORD

Name _____ DOB _____ Practice # _____

Phone Home (___)_____

Phone Cell/Work (___)_____

Pharmacy_____

Pharmacy Phone (___)_____

ALLERGY INFORMATION

_____

_____

_____

_____

Date	Medication and Dosage	Freq	Qty	Refills				D/C'd

1. Print as a two-sided document to continue an accurate flow of information.
2. Please note: this example of a medication form may benefit practices that do not routinely refill prescriptions.
3. Be sure to identify the individual who calls in the refill.