MEDICATION – PRESCRIPTION RECORD

Name _____ DOB _____ Practice # ____

Phone Home _(___) _____

Phone Cell/Work _(___)_____

Pharmacy _____

Pharmacy Phone _(___)_____

ALLERGY INFORMATION

_____

_____

_____

_____

Narcotic Drug Contract [ ] Date ____ Annual Renewal _____;_____;_____;____;____

Date	Medication and Dosage	Freq	Qty	Refills	Staff Initials			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.
4. Include over the counter; herbals; vitamins and recreational drug use.