Preferred Pharmacy 3.2018

Date: _____

Client Name: _____ Date of Birth: _____

- In order to complete your prescription(s) it is essential that we have accurate, legible, and complete information regarding which pharmacy you would like to use.

- ***There will be a delay in being able to submit your prescription if any information is inaccurate, illegible, or incomplete.***

- In order to avoid any delays in completing your prescription(s), complete the following:

Pharmacy Name: _____

Pharmacy Phone Number: _____

Pharmacy Address: _____
Street City Zip Code

- If there is a change in preferred pharmacy, a new form will need to be completed or the new pharmacy information must be called into the office.

Office Use Only

Form completed by: ☐ Client/Guardian ☐ Office Staff Member _____ (initials)

Information entered into system by _____ (initials) on _____ (date)