Prescription Refill Request

***Please allow 48 Hours for Completion**

Date: ______________________________

Patient Name: ______________________________

Birth Date: ______________________________

Phone Number: ______________________________

Physician Name: ______________________________

Medication Name: ______________________________

How it is taken: ______________________________

Dosage: ______________________________

Quantity Requested: ______________________________

Pharmacy Name: ______________________________

Pharmacy Phone Number: ______________________________

Pharmacy Fax Number: ______________________________

For Office Use Only

CMR / ______________ Script Called ______________

☐ Completed

☐ Needs Lab Work
☐ Needs Office Visit
☐ Needs Mammogram
☐ Needs CPE