☒ **Urgent** ☒ **Reply ASAP**

To:	From:
RE Patient:	Date:
Phone Number:	Sender's Phone Number:
Fax Number:	Sender's Fax Number:

Pages Including Cover: 2

---Patient Information Sheet---
PLEASE COMPLETE AND FAX BACK ASAP TO:

Date of Last Visit: _____

Reason for Visit: _____

_____

Allergies: _____

_____

Current Medications: _____

_____

_____

Affected Area: _____

_____

Please remember to circle quantity and refill amount for the attached RX your patient has requested from our company.

PAT ID #:

Prescription Request Authorization

Fax:

Date:

Refills RequestedAuthorized: 5

We request refill/renewal authorization on behalf of your patient

DOB:

Phone:

Please fax or call this request to:

Fax:

Patient:

Signature: _____ Date: _____

Doctor:

NPI:

Phone: Fax:

Dispense as Written: ☒

Comments: