Patient Prescription Information

This form must be filled out completely - TYPE or PRINT information below:

Patient Name: (Last, First, Middle Initial)	Patient SSN	Date of Birth (mm-dd-yyyy)
Patient 134		07/10/1986

MAILING INFORMATION (TYPE or PRINT where the prescriptions are to be mailed)

Patient Mailing Address:

77 Knol Lane
Knol City
KN01 773

Daytime Phone Number (Including Area Code):

Home: Cell:

Today's Date 15/12/2016

Is this a change of address? ☐ Yes ☒ No

Is this a permanent change? ☐ Yes ☒ No

Is this a temporary change? ☐ Yes ☒ No

If temporary, what date does the address end (mm-dd-yyyy)?

NON-SAFETY CAP REQUEST:

Federal law requires that your medication be dispensed in a container with a child resistant or safety cap. If you would like your prescription with an "Easy-Open" lid, **please sign below**:
I request that these prescriptions and all refills of these prescriptions dispensed in "Easy-Open" or NON-child-resistant containers.

Signature: Date:

Medication Allergies

☐ None
☐ Ampicillin
☐ Aspirin
☐ Cephalosporins
☐ Codeine
☐ Erythromycin
☐ Morphine
☐ SAIDS
☐ Penicillin
☐ Sulfa
☐ Tetracycline
☐ Other (specify)

Health Conditions

☐ Arthritis
☐ Asthma
☐ COPD
☐ Depression
☐ Diabetes
☐ Glaucoma
☐ High Cholesterol
☐ Hypertension
☐ Kidney Disease
☐ Liver Disease
☐ Seasonal Allergies
☐ Seizures/Epilepsy
☐ Thyroid
☐ Ulcer/Acid Reflux/ GERD

☒ Other (Specify)

☐ Food Allergy (Specify)

	Medication Name	Name of Medical Provider Who Signed the Prescription
1	Avandia	Practitioner 2
2		
3		
4		
5		
6		
7		
8		
9		
10		

HOW TO OBTAIN MORE ORDER FORMS: You may either photocopy a blank form, or call the VA Health Administration Center at 1-800-733-8387. Forms are also available on the website: **www.va.gov/hac/forms**