PRESCRIPTION TRANSFER INFO SHEET

Today's Date: _____ Date /Time Promised_____
Patient's Contact #_____ Tech Initials: _____
Patient's Name: _____ Patient's Date of Birth: _____
Sponsor's Full SSN: _____ Pharmacy Phone #: _____
Transferring Pharmacy: _____

1. Rx No: _____ Quantity: _____ Last Fill Date_____
   Medication: _____
   Directions: _____
   Physician Info: _____
   Refills Remaining (Verified by RPH) _____Orig. Date: _____

2. Rx No: _____ Quantity: _____ Last Fill Date_____
   Medication: _____
   Directions: _____
   Physician Info: _____
   Refills Remaining (Verified by RPH) _____Orig. Date: _____

3. Rx No: _____ Quantity: _____ Last Fill Date_____
   Medication: _____
   Directions: _____
   Physician Info: _____
   Refills Remaining (Verified by RPH) _____Orig. Date: _____

4. Rx No: _____ Quantity: _____ Last Fill Date_____
   Medication: _____
   Directions: _____
   Physician Info: _____
   Refills Remaining (Verified by RPH) _____Orig. Date: _____

Person Spoken to at Transferring Pharmacy: _____
RPH Receiving Info: _____

PATIENT CONTACTED/DATE/TIME:

_____