# 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-yy)

***MAILING INFORMATION*** (TYPE or PRINT where the prescriptions are to be mailed) Patient Mailing Address: Daytime Phone Number (Including Area Code):

Home: Cell:

Today's Date

**NON-SAFETY CAP REQUEST:**

Is this a change of address? Is this a permanent change? Is this a temporary change?

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

Yes No

Yes No

Yes No

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 Health Conditions

None Ampicillin Aspirin

Cephalosporins Codeine

Morphine SAIDS

Penicillin Sulfa Tetracycline

Arthritis Asthma COPD

Depression Diabetes

Glaucoma

High Cholesterol Hypertension

Kidney Disease Liver Disease

Seasonal Allergies Seizures/Epilepsy Thyroid

Ulcer/Acid Reflux/ GERD

Erythromycin

Other (specify)

Other (Specify)

Food Allergy

(Specify)

**Medication Name**

1

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**Name of Medical Provider Who Signed the Prescription**

**HOW TO OBTAIN MORE ORDER FORMS:** You may either photocopy a blank form, or call the VA Health Administration