

## REFILL REQUEST FORM

Please print out this form to use when requesting a prescription refill from our office. This will help insure the accuracy of your prescription. If you would prefer, you may fax us this form and avoid our voice mail system or need to speak with one of our telephone operators.

Our fax number is: (212) 606-1170

Please allow 24 hours for your prescription to be transmitted to your pharmacy.

We recommend you call your pharmacy before picking up your prescription to verify it being filled.

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Strength: \_\_\_\_\_

Directions: \_\_\_\_\_

How many do want: \_\_\_\_\_

Number of Refills: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_

Pharmacy Phone Number: \_\_\_\_\_

Pharmacy Fax Number: \_\_\_\_\_

THANK YOU!