PHARMACY PRESCRIPTION TRANSFER TEMPLATE

SECTION A: To be completed by the patient or the patient's guardian.
Please include as much information as possible. When finished, hand this authorization to your pharmacy's staff.

PATIENT INFORMATION

NAME (Last, First):	DOB (MM/DD/YYYY):	DOD ID#

Phone #:	Address (Street, City, State, and ZIP Code):
Allergies (*please list all allergies):*	

TRANSFERING FROM INFORMATION	
Pharmacy Name:	Pharmacy Phone #:

PRESCRIPTION INFORMATION	
Medication Name(s):	Prescription #(s):
1.	1.
2.	2.
3.	3.

TRANSFER AUTHORIZATION		
Signature of Patient / Parent / Legal Representative:	Relationship to Patient (if applicable):	Date:

SECTION B: To be completed by the pharmacy receiving the prescription(s)
For pharmacy personnel use only. All fields are required for each prescription requested for transfer.

PHARMACY INFORMATION	
Name of Receiving Pharmacist:	Name of Transferring From Pharmacist:
Receiving Pharmacy DEA (required for controlled substances):	Transferring From Pharmacy DEA (required for controlled substances):
Receiving Pharmacy (Name, Address, City, State, ZIP Code, Phone #, and Fax#):	

DRUG INFORMATION (for #1 above)		**DRUG INFORMATION (for #2 above)**		**DRUG INFORMATION (for #3 above)**	
Drug Name:		Drug Name:		Drug Name:	
Strength:	Quantity:	Strength:	Quantity:	Strength:	Quantity:
Sig / Directions:		Sig / Directions:		Sig / Directios:	
Refills Remaining:	Date Written:	Refills Remaining:	Date Written:	Refills Remaining:	Date Written:
Provider:		Provider:		Provider:	
Order Fill Date:	Last Fill Date:	Order Fill Date:	Last Fill Date:	Order Fill Date:	Last Fill Date:
DEA:	NPI:	DEA:	NPI:	DEA:	NPI: