EMERGENCY PHARMACY REQUEST FORM

PLEASE FAX THIS FULLY COMPLETED FORM ALONG WITH THE PRESCRIPTIONS OR PHYSICIAN ORDERS TO:

1-205-451-1823

Facility Name:	**Date / Time:**
Your Name:	**Good Call Back #:**
Resident Name	**Prescriber Name:**
Resident DOB: _____/_____/_________	**Prescriber Phone #:**
Resident Drug Allergies	
	Total Number of Pages Faxed:

☐ ← Please check here if you have a question & **need the pharmacy staff to call you** (Please make sure you have entered a good call back number)

☐ ← Please check here for **NEW ORDERS** or **REFILLS**

( ) NEW ORDER ( ) REFILL **TIME NEXT DOSE IS DUE:** _________________

MEDICATION(S) REQUESTED (name and strength only):

.____ .____

.____ .____

☐ ← Please check here for **NEW ADMISSION** or **READMISSION**

If new or readmission, do you need all the medications on this fax? **YES** **or** **NO**

If NO, what medications are you requesting to be sent? (name & strength only):

.____ .____

.____ .____

If you have questions, please call 205-451-1822

************** **ONE PAGE PER RESIDENT REQUEST PLEASE** **************