Pharmacy Communication Fax Cover Sheet

Fax Number: (205) 451-1823

Facility: _____Person Sending Fax: _____

Resident Name: _____ Total Pages (incl. cover page): _____

- ☐ **New Resident Moving-In:** (please include Med List and Enrollment/Insurance Information)
  - Resident Expected Move in Date: _____ Resident Room Number: _____
  - First dose of medication from Guardian to begin: _____ (Date /Time)

- ☐ **New Medication Orders or Plan of Care:**
  - First Dose of Medication needed by: Date_____ Time: _____

- ☐ **Refills Needed for the following Medications**:

BARCODE	or MEDICATION NAME	Needed By:

- ☐ **Resident Status Change:**
  - Resident hospitalized
  - Resident has passed away
  - Resident has moved
  - Resident out for extended leave
  - Resident no longer needs pharmacy services

- ☐ **Repack/Profile Only Resident**: Update Orders for MAR, **DO NOT DISPENSE**

- ☐ **Hospice Enrollment**: Hospice Name & Phone Number _____

- ☐ **Replacement Dose Needed**:
  - Medication_____ Date/Time _____
  - Medication_____ Date/Time _____
  - Medication_____ Date/Time _____

- ☐ **Other/Special Instructions**:_____

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