1750 Enterprise Way, Suite 105
Marietta, GA 30067
Ph: 770-635-3301 Fax: 770-635-3302

RESIDENT NAME:_____ **DOB:**_____

DRUG NAME/STRENGTH	DIRECTIONS FOR USE	QTY (a)	REF (b)	DIAGNOSIS

(a.) Unless otherwise specified, with your signature below, the pharmacy will assign 11 refills for non-controlled drugs. Please specifiy the number of refills for controlled drugs
(b.) A diagnosis is required for each medication order

Physician Name: _____ **DEA #:** _____

Physician Signature: _____

Date Signed: _____