

Lexington • Ob Gyn

Prescription Refill Request

Patient Instructions:

In order to obtain a refill of your prescription, please complete this form and fax it to (212) 686-1920. This form is only for refills of current medications. This form can not be used to request a new or a change of a medication.

Patient Name:			
Date of Birth:			
Physicians Name:			
Phone numbers:	Home:	Work:	Cell:
Address:	Street:		
	City:	State:	Zip
Name of Medication:			
Dosage:			
Frequency used:			

Please select one of the following:

- Mail prescription to my home address to use at a local pharmacy.
- Mail prescription to my home address to use with a mail order pharmacy.
- Call in the prescription to my pharmacy:

Pharmacy Name: _____

Pharmacy Phone #: _____

Office use only:

- Prescription mailed on ____/____/____
- Prescription called into pharmacy on ____/____/____. Spoke to _____
- Prescription not refilled because _____

Authorized signature: _____ Printed name: _____