

Prescription Refill Request

Name _____

DOB ____ / ____ / ____

Daytime Phone (____) ____ - ____

Cell Phone (____) ____ - ____

Please have my prescription(s):
ready for pick-up at the office
called to my pharmacy at (____) ____ - ____
mailed to: _____

faxed to: (____) ____ - ____

Prescription # 1: _____
Rx number (if available): _____
Number of tablets: _____
Dosing instructions: _____

Prescription # 2: _____
Rx number (if available): _____
Number of tablets: _____
Dosing instructions: _____

Prescription # 3: _____
Rx number (if available): _____
Number of tablets: _____
Dosing instructions: _____

Prescription # 4: _____
Rx number (if available): _____
Number of tablets: _____
Dosing instructions: _____

- Dr. Restifo
Dr. Thomas
Fax (202) 364-6513

- Dr. Chester
Dr. Schubert
Dr. Umhau
Fax (202) 362-2303

- Dr. Yau
Dr. McBride
Dr. Saleh
Fax (202) 243-0297

- Dr. Klein
Dr. Naujokaitis
Fax (202) 537-0560

- Dr. Ungar
Dr. Li
Fax (202) 362-2573

- Dr. Dooley
Dr. Hansen
Fax (202) 362-3639

- Dr. Sacks
Fax (202) 363-1171

- Dr. Yamamoto
Fax (202) 537-0075

This form may be mailed or faxed to your doctor's office. Please use the fax number directly below your doctor's name in the box above.