

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.