

 FYV
PharMerica Senior Living Pharmacy
Fax Cover Page

PharMerica[®]
Senior Living

TO: _____ FROM: _____
FAX #: _____ UNIT: _____ # PAGES: _____
PHONE #: _____ DATE: _____
RESIDENT NAME: _____
STAFF NAME: _____

Please check all that apply:

- ☐ NEW MOVE-IN (Must include all items and indicate on physician orders medications to be filled):
☐ Face Sheet ☐ Allergies ☐ Insurance card ☐ Enrollment form ☐ Valid physician orders
- ☐ NEW ORDERS – SEND MEDICATIONS
- ☐ NEW ORDERS – ONE-TIME ONLY EMERGENCY: Quantity _____
- ☐ SELF-ADMINISTER: ☐ NEW ORDER – SEND MEDS ☐ PROFILE ONLY
- ☐ DISCONTINUE MEDICATIONS: See orders attached; DC Date: _____
- ☐ PROFILE ONLY – RESIDENT HAS MEDICATION ON HAND
- ☐ PROFILE ONLY – RESIDENT WILL NOT BE USING PHARMERICA SENIOR LIVING
- ☐ STAT MEDICATION (Critical Medications) – Fax, then call pharmacy
- ☐ HOSPICE RESIDENT:
☐ Send Medications (list): _____
☐ Profiled medications provided by hospice (list): _____
- ☐ RESIDENT STATUS:
☐ Physician Change (name, fax, phone): _____
☐ Discharge Date: _____ ☐ Expired Date: _____
☐ Leave of Absence – Hold Meds Until Notified ☐ Room Change: _____
- ☐ CYCLE MEDICATIONS (Quantity needed to get back on cycle schedule):
✓ Medication: _____
✓ Number of Tabs: _____

MISSING INFORMATION MAY POTENTIALLY CAUSE A DELAY IN SERVICE