

PharMerica Senior Living Pharmacy
Fax Cover Page

FYV



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

