



FAX COVER SHEET

KENT

PHONE: (800) 562-8386

FAX: (844) 308-3027

TO:

ATTENTION PHARMACY:

- FILL MEDICATION(S)
- CHART ONLY
- CONTROLLED SUBSTANCE
- CYCLE FILL
- BILLING
- MEDICAL RECORDS/ PHYSICIANS ORDERS

OTHER: _____

FROM:

PHONE: _____

FAX: _____

SENDER'S NAME: _____

OF PAGES: _____ DATE: _____
(INCLUDING COVER SHEET)

Please indicate the items needed when multiple orders are present

COMMENTS:

- NEXT DELIVERY
- OTHER BY DATE/TIME: _____
- DO NOT SEND
- STAT - DOSE DUE: _____
(Urgent medication orders only)

NEW ADMIT/ READMIT: *Medications CANNOT be filled without an order signed, either physically or electronically, by prescriber or physically by licensed nurse*

Will PharMerica be the resident's primary pharmacy? Yes No

Are all medications needed? Yes No

If No, please list which medications are needed _____

Resident uses other pharmacy. Please fill emergency _____ days supply or a quantity of _____.

CONFIDENTIAL: This fax and any documents accompanying this fax transmission are confidential. Information and data contained in this fax transmission belongs to the "facility" listed above and is legally privileged. The information accompanying this fax transmission is intended only for the use of PharMerica. The recipient of this information is prohibited from disclosing, copying, distributing or using this information except as permitted by current law governing privacy of information issues. Such information must be destroyed after its stated need has been fulfilled, unless otherwise prohibited by law. If you have received this fax transmission in error, please notify the "sender" immediately for return instructions.



REORDER FORM

FAX: (844) 308-3027

PHONE: (800) 562-8386

DO NOT INCLUDE NEW ORDERS ON THIS FORM

Facility:

Nursing station:

Ordered by:

Date: _____

1	
---	--

2	
---	--

3	
---	--

4	
---	--

5	
---	--

6	
---	--

7	
---	--

8	
---	--

9	
---	--

10	
----	--

11	
----	--

12	
----	--

13	
----	--

14	
----	--

15	
----	--

16	
----	--

17	
----	--

18	
----	--

Reorders faxed by 12 noon Monday - Saturday will be processed and delivered the same day. All reorders faxed after 12 noon will be processed and delivered the following business day. All reorders faxed after 12 noon on Saturday and all day Sunday will be processed and delivered the following Monday.



ONE OF SHEET

FAX: (844) 308-3027

PHONE: (800) 562-8386

Facility:

Nursing station:

Ordered by: _____

Date: _____

1		QTY
---	--	-----

2		QTY
---	--	-----

3		QTY
---	--	-----

4		QTY
---	--	-----

5		QTY
---	--	-----

6		QTY
---	--	-----

7		QTY
---	--	-----

8		QTY
---	--	-----

9		QTY
---	--	-----

10		QTY
----	--	-----

11		QTY
----	--	-----

12		QTY
----	--	-----



MEDICATION RETURN FORM

FILL OUT THIS FORM AND SUBMIT A COPY WITH MEDICATIONS TO BE RETURNED

Facility: _____

Nursing station: _____

Staff Name: _____

Date: _____

AFFIX RX REORDER LABEL BELOW Rx Number, Resident / Medication Name & Strength	REASON Check One	QUANTITY
RX # NAME MED NAME STRENGTH	<input type="checkbox"/> Discontinued <input type="checkbox"/> Order Changed <input type="checkbox"/> Discharged <input type="checkbox"/> Family Provides <input type="checkbox"/> Other _____	
RX # NAME MED NAME STRENGTH	<input type="checkbox"/> Discontinued <input type="checkbox"/> Order Changed <input type="checkbox"/> Discharged <input type="checkbox"/> Family Provides <input type="checkbox"/> Other _____	
RX # NAME MED NAME STRENGTH	<input type="checkbox"/> Discontinued <input type="checkbox"/> Order Changed <input type="checkbox"/> Discharged <input type="checkbox"/> Family Provides <input type="checkbox"/> Other _____	
RX # NAME MED NAME STRENGTH	<input type="checkbox"/> Discontinued <input type="checkbox"/> Order Changed <input type="checkbox"/> Discharged <input type="checkbox"/> Family Provides <input type="checkbox"/> Other _____	
RX # NAME MED NAME STRENGTH	<input type="checkbox"/> Discontinued <input type="checkbox"/> Order Changed <input type="checkbox"/> Discharged <input type="checkbox"/> Family Provides <input type="checkbox"/> Other _____	
RX # NAME MED NAME STRENGTH	<input type="checkbox"/> Discontinued <input type="checkbox"/> Order Changed <input type="checkbox"/> Discharged <input type="checkbox"/> Family Provides <input type="checkbox"/> Other _____	
RX # NAME MED NAME STRENGTH	<input type="checkbox"/> Discontinued <input type="checkbox"/> Order Changed <input type="checkbox"/> Discharged <input type="checkbox"/> Family Provides <input type="checkbox"/> Other _____	
RX # NAME MED NAME STRENGTH	<input type="checkbox"/> Discontinued <input type="checkbox"/> Order Changed <input type="checkbox"/> Discharged <input type="checkbox"/> Family Provides <input type="checkbox"/> Other _____	

If an order has changed please insure the Pharmacy has the new order

**** PLEASE SEE RETURN GUIDELINES BEFORE SUBMITTING RETURNS ****

Confidentiality Notice: The information in this facsimile may contain confidential health information that is privileged and legally protected from disclosure by the Health Insurance Portability and Accountability Act (HIPAA). This information is intended only for the use of the individual or entity to whom it is addressed. The recipient is obligated to maintain it in a safe, secure and confidential manner. If you are not the intended recipient you are hereby notified that any disclosure, copying or distribution of this information is STRICTLY PROHIBITED. If you have received this information in error, please notify the sender immediately and destroy this communication and all accompanying documents



NEW ADMISSION FORM

FAX: (844) 308-3027

PHONE: (800) 562-8386

Facility: _____

Nursing station: _____

Date: _____

RESIDENT INFORMATION

Resident Name _____ Room _____

Male Female SSN _____ DOB _____

Allergies _____
Use 'NKDA' if resident does not have allergies

Diagnoses & Medical Conditions _____

Primary Physician _____ Phone _____

PHARMACY INFORMATION

Will PharMerica be the resident's primary pharmacy? Yes No

Are all medications needed Yes No

If No, please list which medications ARE needed _____

NOTE: ALL NARCOTIC ORDERS MUST HAVE **PRESCRIBER DEA, SIGNATURE, AND QUANTITY** IN ORDER TO BE FILLED PER DEA REGULATIONS. *INCOMPLETE ORDERS WILL DELAY DELIVERY.*

RESPONSIBLE PARTY INFORMATION

Name _____ Phone _____

Address _____

Prescription Drug Plan _____

ID # _____ Group # _____