



FAX COVER SHEET

SPOKANE

PHONE: (800) 237-2124

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

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

COMMENTS:

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 _____.

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REORDER FORM

FAX: (844) 308-3027

PHONE: (800) 237-2124

DO NOT INCLUDE NEW ORDERS ON THIS FORM

Facility:

Nursing station:

Ordered by:

Date: _____

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ONE OF SHEET

FAX: (844) 308-3027

PHONE: (800) 237-2124

Facility:

Nursing station:

Ordered by: _____

Date: _____

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2		QTY
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10		QTY
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11		QTY
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12		QTY
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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) 237-2124

Facility: _____

Nursing station: _____

Date: _____

RESIDENT INFORMATION

Resident Name _____	Room _____
<input type="checkbox"/> Male <input type="checkbox"/> Female	SSN _____ DOB _____
Allergies _____ <small>Use 'NKDA' if resident does not have allergies</small>	
Diagnoses & Medical Conditions _____ _____	
Primary Physician _____	Phone _____

PHARMACY INFORMATION

Will PharMerica be the resident's primary pharmacy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are all medications needed <input type="checkbox"/> Yes <input type="checkbox"/> No
If No, please list which medications <u>ARE</u> needed _____ _____ _____
NOTE: ALL NARCOTIC ORDERS MUST HAVE <u>PRESCRIBER DEA, SIGNATURE, AND QUANTITY</u> IN ORDER TO BE FILLED PER DEA REGULATIONS. <i>INCOMPLETE ORDERS WILL DELAY DELIVERY.</i>

RESPONSIBLE PARTY INFORMATION

Name _____	Phone _____
Address _____	
Prescription Drug Plan _____	
ID # _____	Group # _____



ATTN: ON-BOARDING

OTC BOX
REORDER FORM

FAX: (844) 308-3027

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ITEMS

CHECK BOX IF NEEDED

ACETAMINOPHEN 325MG	<input type="checkbox"/>	1 BOTTLE
ANTI-DIARRHEAL 2MG	<input type="checkbox"/>	1 BOX
ASPIRIN 325MG	<input type="checkbox"/>	1 BOTTLE
ASPIRIN 81MG CHEWABLE	<input type="checkbox"/>	1 BOTTLE
BARRIER CREAM	<input type="checkbox"/>	5 PACKETS
CALCIUM CARB 500MG	<input type="checkbox"/>	1 BOTTLE
DIPHENHYDRAMINE 25MG	<input type="checkbox"/>	1 BOTTLE
DOCUSATE SODIUM 100MG	<input type="checkbox"/>	1 BOTTLE
IBUPROFEN 200MG	<input type="checkbox"/>	1 BOTTLE
MILK OF MAGNESIA 30ML	<input type="checkbox"/>	5 UNIT DOSES
MULTIVITAMIN	<input type="checkbox"/>	1 BOTTLE
SENNA	<input type="checkbox"/>	1 BOTTLE
FLEETS ENEMA	<input type="checkbox"/>	1 BOTTLE

FACILITY: