

PATIENT MEDICATION INFORMATION

Instructions:

1. Please send a completed Patient Medication Information sheet to Central Pharmacy for each new patient only.
2. Send the Patient Medication Information sheet with the first prescriptions sent to the Central Pharmacy for each patient.
3. Please type or print legibly in ink.

Send to:

Central Pharmacy; 2150 W. Broad Street; Columbus, Ohio 43223-1200

From (clinic name)		Date Information was Taken
Clinic Address (street, city, zip code)		
Patient Name	Patient No.	Age or Date of Birth
Patient Address (street, city, zip code)		
Patient Telephone No.	Patient Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Race <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Other, specify:
Chronic Disease State(s)		
Drug Allergies		
Previous Drug Reactions or Idiosyncrasies		
Other Drugs Patient is Receiving from Sources Other than Central Pharmacy (include over-the-counter drugs)		

DMH-0241 (Rev. 7/00)

DMH-PSC-013

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