MEDICATION ORDER FORM ☐ **RUSH** **Need by**_____ ☐ **REGULAR**

Fax to: (614) 752-0151
or
Mail to: Central Pharmacy Outpatient
2150 West Broad Street
Columbus, OH 43223-1200
(614) 752-0150

Date	# of pages faxed	
Clinic Name		Number
Phone Number	Fax Number	
Signature of person completing form		

INSTRUCTIONS: To request a refill, please place sticker from patient's prescription bottle on the boxes below. If a sticker is not available, please write legibly in the boxes below the client number, client name, Rx number and medication to be refilled. For patients or prescribers new to Central Pharmacy, please send Patient Medication Information or Health Care Provider Record.

CLIENT NUMBER	CLIENT NAME	RX NUMBER	MEDICATION TO BE REFILLED

ORDER TOTALS:	
Total Number of Refills:	_____
Total Number of New Prescriptions:	_____

Confidential Information: Pursuant to State law, the information that is being transmitted is confidential and it must not be reviewed by unauthorized parties. It must be immediately given to the person listed as the recipient. If this information has been transmitted to you in error, please immediately notify the sender.