VA FAX 873-8174

PRESCRIPTION REQUEST
NON-HOSPICE COVERED MEDICATIONS

DATE: _____

TO: _____

FROM: _____
CELL: _____

PATIENT: _____SS#: _____-____-_____
DOB: ____/____/_____

PLEASE WRITE RX FOR THE FOLLOWING MEDICATIONS THAT ARE UNRELATED TO TERMINAL DIAGNOSIS OF

_____

_____ REFILLS EXPIRED
_____ HOSPICE MEDICAL DIRECTOR SUGGESTED MEDICATION/ REQUEST AUTHORIZATION
_____ PATIENT UNABLE TO RETURN TO VA DUE TO HEALTH STATUS
_____ REQUEST VA PHARMACY MAIL MEDICATION **____ FAMILY WILL PICK UP**

VA PHYSICIAN COMMENTS: _____

MEDICATION	DOSE/ ROUTE/ FREQUENCY	REASON TAKING

VA PHYSICIAN: _____ DATE _____

PLEASE CALL 771-8979 FOR QUESTIONS