EXCELLENT CARE
PSYCHIATRY

Excellent Care Psychiatry Pharmacy Policy

This will be used for calling in your prescriptions or sending them electronically. Please inform us if you would like to switch pharmacies.

MUST BE FULLY COMPLETED

Pharmacy Name : _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

PLEASE LIST YOUR MEDICATIONS, FREQUENCY, DOSAGE:

_____

_____

_____

_____

_____

_____

Use back side if needed!

_____ _____

Patient Signature **Date**