

NORTHWEST ADMINISTRATORS SALARIED EMPLOYEE MAIL ORDER PRESCRIPTION ORDER FORM

PATIENT NAME		PATIENT ID #		PATIENT DATE OF BIRTH		
SHIPPING ADDRESS <input type="checkbox"/> NEW ADDRESS			EMAIL ADDRESS			
CITY, STATE, ZIP CODE			DAYTIME PHONE			
LIST ANY CHRONIC MEDICAL CONDITIONS		LIST ANY DRUG ALLERGIES		EVENING PHONE		
				VISA OR MASTERCARD No.		EXP. DATE
				TRANSFER PHARMACY NAME & PHONE (IF APPLICABLE)		

RX NUMBER	NAME OF DRUG	STRENGTH	GENERIC OK?	QUANTITY	DAYS SUPPLY	PRESCRIBING PRACTITIONER

I CERTIFY THE INFORMATION GIVEN HERE IS CORRECT AND AUTHORIZE MY PHARMACY TO FILL THE ENCLOSED AND/OR LISTED PRESCRIPTIONS.

CHILD RESISTANT CAP? YES
PLEASE INITIAL NO

PATIENT'S SIGNATURE

DATE