Patient Name:_____
Patient SSN:_____

SPECTRUM PHARMACY OF ARIZONA

PATIENT MEDICAL AND PHARMACEUTICAL INFORMATION

Primary Care Physician Information
Physician Name:_____ Facility/Clinic Name:_____
Address:_____City:_____State:____ZIP:_____
Phone Number:_____Fax Number:_____

Previous Pharmacy Information
Name:_____
Address:_____City:_____State:____ZIP:_____
Phone Number:_____Fax Number:_____

- ☐ Patient has been filling all prescriptions at this pharmacy
- ☐ Patient has been filling prescriptions at multiple pharmacy locations (please provide location information)

Patient Prescription Information
The patient's Face Sheet may be attached in lieu of filling out the information below, if applicable.

HOSPICE?	Rx NUMBER/NAME	STRENGHT	QTY	DIRECTIONS	PRN?
☐	_____	_____	___	_____	_____
☐	_____	_____	___	_____	_____
☐	_____	_____	___	_____	_____
☐	_____	_____	___	_____	_____
☐	_____	_____	___	_____	_____
☐	_____	_____	___	_____	_____
☐	_____	_____	___	_____	_____
☐	_____	_____	___	_____	_____
☐	_____	_____	___	_____	_____

☐ **Check here to receive MARs for this patient**

Please list any known allergies for the patient:
_____
_____

Diagnoses:
_____
_____

Please fax completed form to (520) 296-0417 or email to info@spectrumpharmacyaz.com

revised 01/2016