WARNER WELLNESS INSTITUTE
Prescription Refill Request

Patient Instructions:

In order to obtain a refill for your prescriptions, please complete this form and fax it to (202) 723-1992. This form cannot be used to request a new or change of a medication.

Patient's Name: _____

Date of Birth: _____

Physician's Name: _____

Phone Numbers: Home: _____work: _____cell: _____

Address: Street: _____

City: _____State: _____Zip: _____

Name of Medication and Dosage: _____

Frequency Used: _____

Please select one of the following:

_____Mail prescription to my home address to use at a local pharmacy.

_____Mail prescription to my home address to use with a mail order pharmacy.

_____Call in the prescription to my pharmacy:

Pharmacy Name: _____

Pharmacy Phone#: _____

Office Use Only:

_____Prescription mailed on: _____/_____/_____

_____Prescription called into pharmacy on ____/_____/____Spoke with: _____

_____Prescription not refilled because: _____

Authorized Signature: _____Print Name: _____