OUTPATIENT PHARMACY
DROP-OFF PRESCRIPTION FORM

Date ____________ **Time of Drop-Off:** ____________________

- Patient's identification is required upon medication pickup
- Medication(s) will be returned 7 calendar days from drop-off date

Patient's Name ____

Patient's Birthdate ____

Patient's DOD ID/Sponsor's SSN ___________________________

Best contact phone # ____

Child's weight (kg/lbs.) ______________________________________

List any drug/food allergies/pregnant/breastfeeding:

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PLEASE CHECK THE BOX IF YOU ARE A ONCOLOGY PATIENT ☐

NAME OF MEDICATION(S) REQUESTED

1. ____

2. ____

3. ____

4. ____

5. ____

FOR PHARMACY STAFF USE

Total # of Rxs: ___________

Pharmacy Staff Name: ____