



Instructions: This form is for your use in requesting additional medications or supplies. Mail in at least 14 days before your supply is exhausted. Before mailing this form, please check it over to be sure all patient identification blanks have been completed. Prescriptions more than six months old cannot be refilled.

Table with 2 columns: PRESCRIPTION NUMBER and NAME(S) OF MEDICATION AND/OR MEDICAL SUPPLY. Includes instruction: (Be sure to list only current prescriptions)

Caution - Always carefully check all medications after receiving them. If any medication appears to be different from what you have been taking, please immediately phone the Pharmacy() for clarification.

Please be sure that name and address are entered in the space to insure prompt delivery of medication.

PATIENT'S IDENTIFICATION (Print or Type)

Form fields for patient identification: NAME (Last, First, Middle Initial), SOCIAL SECURITY NO., DATE, NUMBER AND STREET, TELEPHONE (Include area code), CITY, STATE AND ZIP CODE, PATIENT'S SIGNATURE

The information requested on this form is solicited under authority of Title 38, U. S. Code, Veterans' Benefits, and will be used to process your prescription in the shortest time. Disclosure is voluntary. However, if information is not furnished the processing of of your prescription may be delayed. Failure to furnish this information will have no adverse effect on any other benefit to which you may be entitled.