

DATE: _____

PRESCRIPTION FAX FORM

to be faxed by the practice only

ALL AREAS MUST BE COMPLETED FOR PROPER PROCESSING

Payment Terms

- Ship to patient- Bill practice
- Ship to practice- Bill patient
- Ship to patient- Bill patient
- Ship practice- Bill clinic

Practice or client CC# (if applicable): _____

Expiration date: _____

DVM Information

Prescribing Doctor: _____

License # : _____

Expiration date: _____

DEA # : _____

Expiration date: _____

Practice Information

Practice Name: _____ Address: _____ City: _____

State: _____ Phone Number: _____ Email Address: _____

Client Information

Pet Parent Name: _____

Address: _____

Phone Number: _____

*DOB: _____ *Driver's License #: _____

Pet Name: _____ Species: _____

Sex(M/F): _____ Weight: _____ DOB: _____

Prescription Information

New Prescription

Refill

Rx refill number

Drug Name: _____ Strength: _____ Quantity to dispense: _____ # Refills: _____

Dosage form: _____ Preferred flavor (if applicable): _____

Instructions:

Controlled Substance: Yes No

**If yes, pet parent's DOB and Driver's License Number Required.*

Note: All orders that include controlled substances will require a signature at delivery.

DVM Signature

CONFIDENTIALITY NOTICE

The attached document contains information that may be confidential and is intended only for use by the addressees. If you have received this facsimile in error, please notify us immediately by telephone at 877-518-4589.