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